

Pathway Decisions in Differential Response

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Dedication

This dissertation is dedicated to all the children, young people, and their families who have a right to a seat at the table around all decisions, assessments and planning that affects them. They have so much to bring and are so much more than the sum total of their challenges.

Abstract

This qualitative study examines the factors practitioners involved with the child and family services agency in Washington DC consider when making decisions specific to pathway assignment (investigation/family assessment) in a differential response system for screened in referrals/reports alleging child abuse and/or neglect. Twenty social work, law and nursing professionals participating on teams determining responses for referrals regarding child maltreatment concerns participated in in-depth, audio recorded individual interviews engaging their views on the factors they consider in the pathway decision. Thematic analysis yielded seven factors that were most often considered in the pathway decision making process: Identity of the reporter, perceived urgency to see the child(ren), knowledge of the family's willingness to engage in services voluntarily, perceptions and assumptions about the family, the health and expertise of the team's participants, knowledge about supports and resources available and used by the family, and family complexity/challenges; a framework was developed describing how these factors impacted the pathway decision. Participants offered their perspectives on the key strengths of the pathway decision process: working collaboratively, sharing responsibility, increasing confidence, and building expertise.

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Chapter 1 Introduction

Social workers, along with other human service and medical practitioners are frequently faced with making decisions that have critical and long lasting consequences for children, young people and their families. When confronted with complex and problematic situations, the statutory child protective service agency must decide upon actions and interventions in a context of limited knowledge, conflicting values, time frame restrictions, and intense emotions. Basing those decisions on a holistic understanding of how a family operates within its own system and within its cultural and community context is essential.

The child protective service agency, in a number of the English speaking countries in particular, has, over time, been charged with the concurrent and sometimes conflicting responsibility of both protecting children and supporting families. The complexity of managing these dual aims is further challenged by the social context in which the work is done. There are differing assumptions about what is defined as abuse, differing legislative mandates regarding agency powers and duties to intervene, and differing options, accessibility and desirability available regarding effective interventions (Munro, 2002).

Every jurisdiction in the United States with responsibility for responding to community concerns regarding child safety and well-being is provided statutory authority to guide the initial agency response decision. On a daily basis, multiple child protective service agency practitioners screen community concerns and must decide whether the referral of alleged child maltreatment meets specified

criteria and includes sufficient information to activate a response. Historically, the critical decision was whether the agency would initiate an investigation; such a decision results in a child protective service investigation guided by statute and driven by formal forensic procedures. Two-thirds of such community referrals that are made are considered to meet the baseline criteria for intervention. Over half (63.4%) of all referrals come from professionals such as teachers, law enforcement, doctors, social service and mental health practitioners (US Department of Human Services, 2015). The Children's Bureau and American Humane Association both published model legislative reporting guidelines in the 1960's; subsequently, legislation was passed in almost all states requiring the mandated reporting of child abuse and neglect concerns. The passage of the Federal Child Abuse Prevention and Treatment Act (CAPTA) in 1974 included provision that required states to enact reporting laws to qualify for state grant funding; most states had laws already in place by that time. The result of such reporting laws led to an increase in the rate of reporting which in turn supported the need for the statutory agency to develop criteria for making preliminary decisions about whether to screen in or screen out reports for formal response. Screening and eligibility decisions across jurisdictions are made in a number of different ways – individually by child protective service staff with supervisor review, individually by supervisor, and in group and panel processes. Jurisdictions vary in size and are represented by both state supervised, county administered and state administered systems with centralized intake/screening

processes. Jurisdictions across the United States describe devoting attention to the issue of inconsistencies. They are employing a number of strategies to work toward greater consistency (e.g. development of clear criteria, posted prompts describing criteria, decision support tools, frameworks for organizing information, and follow up discussions regarding decisions) (Loman & Siegel, 2014; Siegel & Loman, 2006; Winokur et al, 2014; Sawyer & Lohrbach, 2005; Baird & Wagner, 2000).

The District of Columbia initiated a differential response in child protective services in October, 2011 and expanded to full capacity in October, 2012. Differential response allows for choices in how an agency responds to screened in referrals alleging child abuse and/or neglect. This initiative authorized the public agency to provide a family assessment process for some accepted referrals of child maltreatment. Within this process the agency is required to make a determination regarding the need for child protective service and to set aside the requirement to make a determination of whether or not child maltreatment has occurred.

In December, 2010, Congress passed the reauthorization of the Child Abuse Prevention and Treatment Act (CAPTA). This bill included differential response provisions throughout CAPTA with references to addressing an alternative approach to protecting children from harm. The Department of Health and Human Services was charged with addressing best practices in differential response. Best practices included training of personnel, dissemination of

research and information. These activities allowed for the use of basic state grant funds for improving child protective services. There was a state grant eligibility requirement to identify “as applicable” policies and procedures around the use of differential response (CAPTA Reauthorization Act of 2010).

The R.E.D. (Review, Evaluate and Direct) Team was established in Olmsted County, Minnesota in 1999 for the provision of both structure and group process. This process included the **review** of alleged reports of child maltreatment, an **evaluation** of the available information specific to identified criteria and served to **direct** a decision regarding the agency response pathway. The R.E.D. Team addresses the following questions: Does the information contained in the report meet the statutory threshold for intervention? And if the information contained in the report does not meet the threshold for child protective services intervention, should it be referred for child welfare and/or community services? Does an accepted (screened in) report require a forensic child protection investigation or does the information contained in the report present as a child safety and/or family support concern that can be addressed through a family assessment response? (Sawyer & Lohrbach, 2005).

The R.E.D. Team, modeled after Olmsted County was implemented at the screening decision point in the Child & Family Services Administration in the District of Columbia in January, 2013. In the District of Columbia, similar to Olmsted County, the use of a group decision making process is a key principle underlying the practice approach that supports the view that the decision to

screen in or screen out a report alleging child maltreatment is an agency decision rather than an individual decision.

A typical example of a referral that may initiate a response pathway specific to an assessment with investigative procedures would be concerns that were screened in (meeting the threshold for abuse and/or neglect) regarding an adult in a caregiving role who may have hurt a child sexually. There are specific forensic interviewing procedures that are required in these situations, often additionally involving law enforcement.

An example of a referral that may initiate a response pathway specific to a family assessment without investigative procedures would be concerns that were screened in (meeting the threshold for abuse and/or neglect) regarding a young child who was unsupervised and was without any known physical injuries or negative health consequences as a result.

An example of a referral that would likely generate discussion and the presentation of differing views about pathway choice would be concerns that were screened in (meeting the threshold for abuse and/or neglect) regarding a domestic violence (adult intimate partner against partner) incident during which the child may have intervened and gotten physically hurt. The available information described that neither adult intended to hurt the child. However, the child was hurt due to the actions of a caregiver and could be perceived as a recommendation for an assessment with investigative procedures due to the injury. Alternatively there may be a viewpoint that, given the information

regarding unintentional injury that a family assessment without investigative procedures would be indicated and looked at as an opportunity to offer a different way of providing support to the family.

Purpose of this study

The purpose of this study is to understand and describe how practitioners make decisions in the direct practice context by examining factors influencing decision making that present in surfaced themes. Interviews were conducted and the content was utilized to develop the themes and identify subsequent factors that influence the decision making process at the screening decision point and pathway choice in a child protective service agency context. This study will contribute to knowledge building in the field of child welfare – specific to decision making in child protective service systems where there is a differential response. This study will further contribute to the District of Columbia Child and Family Services Agency's understanding of its initial decision making group processes and practices.

Research Question

What do participants describe as affecting their pathway decision making process in a child protective service differential response system?

Theoretical lenses

This study is informed by decision theory as a basis for understanding the underpinnings of the reduction of uncertainty in decision making as applied to child protective service decisions and through the lens of decision making

ecology which outlines and acknowledges the complex set of interactions that are in play and influence the decisions that are made – particularly the screening decision. The focus of this study is within the context of the process in which both the screening and pathway decisions are made.

Decision theory has been defined as “a body of knowledge and related analytical techniques of different degrees of formality designed to help a decision maker choose among a set of alternatives in light of their possible consequences” (Baird & Rycus, 2004; Web Dictionary of Cybernetics and Systems, 2004). Decision theory aims to reduce the uncertainty inherent in decision making by establishing priorities, increasing accuracy and consistency and improving the use of available resources. These objectives are consistent with the desired outcomes in the child protective service delivery system. The complex decisions facing the child protective service agency require an ability to analyze, weigh and synthesize a great deal of information and to use available information to guide actions toward achievement of a pre-determined goal (intervention in matters negatively impacting child safety) (Baird & Rycus, 2005). Dawes (1993) referenced the need to “break down a problem into its components” in an essay he wrote on the technology of decision making, in order to improve the effectiveness of decisions. Given that all decisions ought to be based on the most relevant information available, it must also be recognized that decision making in child welfare will also depend on both the amount of information gathered at each decision point as well as the relevance of that

information to the decision at hand. Decision theory examines data through two categories; “information” that aids in the reduction of uncertainty and “noise” representing additional information that may be outside the scope of and relevance to the problem that is being considered (Baird & Rycus, 2005). The group process represented in this study utilizes the Consultation & Information Sharing Framework®. This framework assists in critically thinking through the additional information (“noise”) that may be presented and organized within the categories of either “complicating factors” or “gray area” and the relevant information, including any known history of past child maltreatment concerns and any described impact on the child(ren) is detailed under the category of “reason for referral”; the purpose is to aid in the evaluation of the information against specified statutory criteria in the decisions to accept the referral as a valid report of maltreatment and subsequently the response pathway choice.

Decision theory is characteristically expressed in mathematical terms such as probability and decision trees as it utilizes research to isolate and quantify the kind of information that is most relevant to a specific decision - thereby separating relevant information from noise (Baird & Rycus, 2005). There are inherent limitations with the uptake of decision theory as applied in social work settings due to the seemingly conflicting impersonal nature of mathematical and predictive constructs alongside practice values and social work education focused on humanistic, relational, and individualistic approaches to working with families. Rycus and Hughes (2003) also discuss the challenges associated with

a general reluctance on the part of social workers to accept any form of standardization as a mandate that can undermine responsiveness and use of self in relationship to intervention and the assessment of individual family needs.

Decision theory is additionally relevant to this study because the criteria for the screening decision was developed within a consensus based decision support tool based on this theory and the pathway decision guidance was developed specifically as a decision tree also based on this theory.

There is a paucity of information available specific to the study of the screening and pathway decisions in child protective service practice so this study utilizes the key work of researchers whose work remains relevant and of interest. The absence of available material underscores the significant contribution of this study. Baumann, Kern & Fluke (1997) more fully examined and explained the complex contexts of child protective service system decision making as the reciprocal relationships that occur between specific family case, organizational, community, and individual factors and the resulting case decisions and client outcomes. This complicated set of relationships is referred to as the “decision making ecology” of child protection. For example, the screening decision (whether to formally investigate/assess or not) has been described as a set of complex interactions between federal and state laws, organizational policies, procedures and norms, interpretations of those laws, policies, procedures and norms by child protective service practitioners and the number of layers within any organization that are included in the decision making process (Wells, 1997).

Reporting on major study findings specific to child protective service screening practices, Wells and colleagues (1995) go on to further describe that case related factors such as type of allegation, amount and quality of information available at the referral point, referral source, the child's age and the number of previous reports are significant factors in determining whether that referral is screened in (accepted for investigation or assessment). The literature suggests that the specific family characteristics may carry the greatest influence on decision making when compared with organizational and practitioner factors (Baumann, Schwab, & Schultz, 1997). Wells et al (1995) additionally point out that there is some evidence that the specific practice norms within the local decision making office supersedes all other factors in the decision to investigate. This study describes a child protective service agency that has been under a class action law suit for twenty-seven years and has developed a significant culture of fear based on continual scrutiny and practice norms that are compliance based with observable emphasis on procedural mandates and transactions. Prior to implementing the Hotline R.E.D. Team, the District of Columbia was screening in 90% of all referrals, struggling with making any decisions at all.

Chapter 2 Literature review

This literature review includes three major topic areas: Differential response in child protective service delivery describes the overarching context of the kind of system design represented in this study where there is legislative approval for the child protective service agency to provide more than one way to respond to community concerns regarding child maltreatment, therefore requiring that at least two formal decisions be made at what is commonly referred to as the “screening decision point” – whether to respond at all and if so, how to approach the family. The second topic area explores decision making specific to child welfare/child protective service delivery, outlining the commonly understood decision points and describing the effective decision making models and questions they are designed to respond to that are employed across child protective service systems. The decision making process explored in this study takes place in the context of a group process and the third literature review is included on group process in decision making outlining described strengths and challenges.

Differential Response in Child Protective Service Delivery

According to the 2015 U.S. Department of Health and Human Services (USDHHS) nearly 4 million referrals alleging child maltreatment are made to public child protective service agencies across the United States each year. Approximately 62% of those referrals are “screened in” meeting baseline criteria for child abuse, neglect or dependency as set forth by State law, policy, or

protocol. Child protective service agencies are required to respond in some way to all screened in reports (Gilmore, 2010).

Nigel Parton and Richard Mathews (2001) have described the transformative nature of this explosion of child abuse reports on the child welfare system using Western Australia as the example. The time and resources devoted to investigative processes has resulted in fewer resources available for more wide-ranging prevention and follow up family support services. The concentration on child protective service investigations has effectively impacted other child welfare services so that child welfare has become more narrowly defined as child protective services (Bersharov, 1990; Pelton, 1991; Giovannoni & Becerra, 1979).

Differential response refers to the way a public child protective service agency can be organized to respond in more than one way to screened-in reports of child maltreatment based on such factors as the type and severity of the alleged maltreatment, number and sources of previous reports, and the willingness of the family to participate in child protective services. The number of response options, or pathways and criteria for the different response options, in a differential response-organized child protective services (CPS) system varies based on state policies or protocols (American Humane Association, 2012). Similar activity is ongoing within the larger international community and specifically in jurisdictions within Canada and the Republic of Ireland (Lohrbach, 2011).

In 1993, the states of Missouri and Florida passed legislation to allow implementation of Differential Response in their child welfare systems. By 2012, 20 states had implemented Differential Response either statewide or in one or more regions/pilot sites, and Differential Response was implemented within tribal jurisdictions in 5 additional states. A number of additional states (e.g. California, New Jersey) have implemented similar initiatives that do not meet the core criteria put forth by American Humane Association in 2006.

Florida's Family Services Response System pilot was implemented statewide during 1994 and 1995. Implementation and model fidelity was found to be varied between participating counties, leading some to be termed "high implementing" and others "low implementing" counties. A 1996 USF-FMHI evaluation found general support for the Family Services Response System by investigators, districts and community stakeholders; however Florida's Dependency Court Improvement Program raised concerns about inconsistent implementation of the Family Services Response System and about child safety, recommending a return to traditional protective service investigations for all reports. The Family Services Response System was repealed by the Florida legislation in 1998. In 2003, the Florida Protective Investigation Retention Workgroup (PIRW) recommended piloting of an "Alternative Response" (AR) system; pilot projects were implemented in three counties during 2008. A 2009 Florida Department of Child and Family (DCF) services report on the pilot recommended expansion of AR statewide.

The state of Missouri was one of the first to adopt a Differential Response system, passing initial legislation in 1994 for a 2 year pilot project. The legislation specified that Differential Response be implemented in five Department of Family Service (DFS) locations statewide; no additional funds (beyond “business as usual”) were allocated for differential response start-up and implementation. Despite the limited authorization for the five pilot sites, differential response was implemented in fifteen counties including part of the city of St. Louis during 1995-1997 (Loman & Siegel, 2004). Assignment to what was referred to as the “DR (differential response)” or “SR (support response)” track was based on severity and nature of the reported allegations, however could be re-tracked if appropriate following initial contact and information gathered. Child protective service (CPS) staff in the differential response pilot counties were required to become “generalist” caseworkers so that assigned family cases would remain with them throughout the life of the relationship between agency and family. A quasi-experimental research design was employed for the evaluation study, with matched non-DR-pilot Missouri counties serving as the comparison group. The data evidenced that the DR pilot counties utilized the assessment track with about 70% of all screened in reports during the study period. Hotline (initial screening decision point) reports decreased markedly in pilot counties over the course of the DR study period and DR pilot counties showed fewer new subsequent reports among assessment families with no evidence of any decrease in child safety. The difference between DR and

comparison families in subsequent maltreatment reports, though statistically significant, was only about 3%. Ultimately, Missouri implemented its differential response approach statewide in 1999; the states early pilot study has been a model for subsequent DR initiatives in Minnesota, Ohio, New York and elsewhere. Among the most noteworthy lessons learned in Missouri were that poverty and related issues are among the primary difficulties affecting many families referred to the child protective service agency and that the provision of basic, concrete services can help many families referred to provide safe homes for their children (Siegel, 2014). Gary Siegel (2012) noted numerous issues in the implementation of differential response: Caseworkers were asked to implement DR without startup resources and with advice yet little training contributing to inconsistencies in approach. The absence of services limited the effectiveness of the DR approach in some areas particularly impacting family support activities. The reference to “voluntary” was interpreted variously in different areas, and families served in the DR track were re-tracked to the investigative track more quickly in some pilot sites than others. This particular issue regarding interpretation of “voluntary” was a prominent theme in this study and is outlined in the findings section. There were model fidelity issues in some DR pilot sites, with caseworkers utilizing an initial investigative approach even with family cases assigned to the DR track.

In 2006, American Humane Association and the Child Welfare League of America jointly conducted a national study of differential response models and

cited the following core elements that must be present to meet criteria for a differential response system in child protective services (National Quality Improvement Center on Differential Response, 2009; Kaplan & Merkel-Holguin, 2008; Merkel-Holguin, Kaplan & Kwak, 2006). The first element is the presence of two or more discrete response pathways for **screened-in** reports, including an assessment pathway with forensic investigation procedures and a family assessment pathway without forensic protocols. The second element requires that the establishment of discrete response pathways is formalized in statute, policy, or protocols to clearly guide practice. The third element designates that the initial pathway assignment is based on local criteria and may depend on an array of factors (e.g. presence of imminent danger, level of risk, number of previous reports, source of the report, and/or presenting family characteristics, such as type of allegation and age of the child(ren) victim). The fourth element specifies that the initial pathway assignment can change based on new information obtained by the agency, altering the risk level or safety concerns; this pathway change can go in either direction – family assessment to investigation or investigation to family assessment. The fifth element, which has often been misinterpreted, outlines that services have a voluntary component in a family assessment without the investigative protocols - meaning that families can choose to receive the investigation response rather than the family assessment response and following the completion of a family assessment may accept or refuse any ongoing child protective services if there are no identified child safety

concerns. Regardless of whether the response assigned is an investigation or a family assessment, neither of those is voluntary. The sixth element clarifies that there is no formal determination/substantiation of child maltreatment made in the family assessment response pathway and the seventh element subsequently outlines that since no determination of maltreatment is made, no one is named as a perpetrator and, element number eight specifies that no names are entered into the central registry for individuals who are served through a family assessment pathway.

Applying these criteria, approximately 20 States are either using a statewide differential response system or have implemented differential response in localities at the time of writing the Quality Improvement Center on Differential Response [QIC-DR], 2009 issue brief and the District of Columbia began in 2011. At least six additional States, tribes, or jurisdictions are known to be considering or planning implementation of differential response, including Puerto Rico.

The development of differential response systems reflects an attempt to adjust policies and practices to the fundamental importance of distinguishing between protective investigation where the forensic procedures of gathering evidence must be a critical priority from assessment where family functioning and the needs (e.g. basic, developmental and complex) of children should be at the center (Anselmo et al, 2003; Waldegrave & Coy, 2005; Waldfogel, 2001).

There is an absence of consensus on specific guidelines to inform decisions about pathway choices and decisions are frequently left to the discretion of

individual practitioners and/or supervisors (Institute for Applied Research St. Louis, 2010; Siegel & Loman, 2006) and some jurisdictions are utilizing a group decision making process (Sphere Institute, 2006; Sawyer & Lohrbach, 2005). Additionally, there is considerable variation between jurisdictions regarding when the pathway decision is made. A response pathway may be immediately identified at the first report or following an initial risk assessment or investigation (US Department of Health & Human Services, 2007).

While there is broad agreement that differential response represents a meaningful attempt to provide the best possible service to families and to address the gaps in family support approaches, there are a number of current issues surrounding differential response that are being discussed in the literature. Hughes et al (2013) have initiated a fierce discourse focused on the problems associated with inconsistencies with implementation, the absence of a standardized practice model, potential disparities in resource allocation to families served through an investigation in contrast to a family assessment (funding had been specifically allocated to family assessment during pilot implementations in a number of jurisdictions involved in evaluations) and brings into question the sufficiency of data to confirm the safety of children served through a family assessment. L. Anthony Loman and colleague Gary Siegel (2013) who have conducted multiple randomized experimental design studies specific to differential response, have responded with clear agreement around concerns with implementation inconsistencies however they argue that the most

consistent findings in their studies have been that families respond more positively to the family assessment process than the forensic investigation and call the question that if the family assessment is done without endangering the children what would be the basis of objection? Their findings have repeatedly detailed that children are just as safe in a family assessment as an investigation. Baird et al (2013) have added to the discourse citing that although differential response implementation is inconsistent from site to site, all are designed to provide enhanced service to families who are variously identified as low risk. One of the inherent complications is in the definition of “low risk”. Most jurisdictions that are implementing differential response are utilizing an actuarial risk assessment tool at the close of either an investigation or a family assessment to formally determine a risk level regarding likelihood of recurrence of maltreatment. The pathway assignment is prior to the formal risk assessment so the baseline criteria for risk are variably identified at this point. As cited in a subsequent discussion by Waldfogel (2009), the prevention efforts with service provision to low risk families is an increasing phenomenon, yet may be problematic when resources are scarce and the concern would be that the allocation of those resources to high risk families may erode. Another concern discussed in Baird, et al (2013) focuses on the absence of a clear definition of which families should be eligible for a family assessment. As the Hughes, et al (2013) study notes, if the agency routinely accepts the low risk rating and concentrates on family support concerns, critical safety concerns could be

overlooked. This issue of clear definition of pathway decision is precisely what this study and its findings aim to contribute to the scarce body of knowledge currently available.

Decision Making in Child Welfare

Child protective service practice has historically been described in terms of decision points; making effective decisions that promote outcomes of safety, well-being, stability and security of care (e.g. permanence) for abused and neglected children has been a priority. Additionally, the timely and accurate identification of children who are at high risk for maltreatment either imminently or at some point in the future is essential to ensuring the most effective decisions to secure their safety (Baird, C. & Rycus, J., 2005).

The first decision point is variously referred to as the screening decision; the agency has received a referral alleging and/or describing concerns regarding child maltreatment and the screening decision determines whether the agency will accept the referral as meeting the statutory requirement for involuntary intervention by the government specific to a family's care of their child(ren). This decision sets in motion a number of subsequent occurrences - mandated investigation or assessment by the government into the private lives of families and opportunities for identification and protection from abuse and neglect along with access to resources and specific services (Wells, et al, 2004). While the child protective service agency has historically focused on preventing subsequent maltreatment in high risk families where referrals have been

screened in for investigation/family assessment, there are also developing prevention services for children at lower risk where referrals have been screened out (Waldfogel, 2009).

The literature on decision making in child protective service practice shows that improved decisions could be made that better safeguard children and their families; it illustrates that maltreatment is related to structural factors including the unique agencies in which families are seen (Wells, et al, 2004).

With a number of competing models of decision making, Crea (1993) describes two central questions that the field of child welfare is faced with: What are the most effective ways to gather information and utilize that information to encourage the most consistent and informed child welfare decisions? And, based on available evidence, which approaches to decision making would make sense for jurisdictions to select to guide organizational practice? This study describes a multi-disciplinary group decision making process where information is gathered initially through the engagement and interviewing by a hotline social worker of the caller making a report/referral regarding child maltreatment concerns. During the actual R.E.D. Team process, the referral is available and read within the group and additional information is gathered through the agency's Statewide Automated Child Welfare Information System (SACWIS) – in the District of Columbia this system is referred to as FACES.NET. The FACES.NET search is focused on prior known child protective service history and is documented in the Consultation & Information Sharing Framework®. All available information is

organized within the framework including a pictorial representation of the family/extended family membership (genogram), described family strengths/protective factors alongside complicating factors/risk factors in addition to the details of the child maltreatment concerns (reason for referral). This information is evaluated through a consensus based screening decision support tool that is linked to the District of Columbia's child abuse/neglect statute. A decision tree illustrating pathway decision criteria is posted for guidance and discussion. This decision making process is regularly under quality service review to ensure fidelity to the model. Decisions are reached by consensus following critical appraisal and discussion of dissenting views of the information and attention is given to what Sutherland (1992) describes in a summation of the research findings on the many ways people have of avoiding challenges to their beliefs that impact decision making:

“First, people consistently avoid exposing themselves to evidence that might disprove their beliefs. Second, on receiving evidence against their beliefs, they often refuse to believe it. Third, the existence of a belief distorts people's interpretations of new evidence in such a way as to make it consistent with their belief. Fourth, people selectively remember items that are in line with their beliefs” (p. 151).

Group Process and Decision Making

The literature suggests that groups are typically expected to result in better informed decisions than individual decision making due to the aggregate of information available that is uniquely held by participants of a group (Crea, 2010). The discussion that occurs in groups may also help correct inconsistencies and

inaccuracies held by individuals by producing decision alternatives as a result of individual biases being counteracted by other group members with opposite biases. However, Stasser & Titus (1985) found that group members had a tendency to withhold uniquely held information and group discussions were dominated by information shared in common before the meeting began as well as information presented in support of members existing preferences (confirmation bias). The exchange and sharing of information is an important process in decision making groups. The ability of groups to consider complex information and to intentionally consider information from diverse sources is the primary reason that groups are expected to make better decisions than individuals acting alone.

In 2004, Kerr & Tindale presented a research summary with the following findings: One of the pitfalls to group decision making – particularly in groups absent a leader or facilitator – was discussed in groups seeking consensus. If group members already share the same preference for specific outcomes, groups may rush to an early consensus by reducing the amount of information exchange. Given that unshared information tends to surface the longer groups engage in discussion it may be useful to ensure that at least one group member has access to all unshared information before convening the group. The group process in this study has multiple roles among the diverse participants – the role of the facilitator is a primary one and ensures a comprehensive appraisal of the information and attends to the focus and purpose at hand. The Consultation &

Information Sharing Framework® includes a category specifically to locate speculative, incomplete or unknown information to avoid, as much as possible, the kind of conclusions that can be inaccurately drawn through speculation and assumptions. Kerr & Tindale (2004) further describe that group participants tend to be perceived as more knowledgeable and competent when they present information already known by other group members. Allowing group members access to information contained in records can expose hidden biases and reduce reliance on one member alone. Although, at times, child protective service supervisors may have access to information ahead of time, the group is generally apprised of all information together and additional information gathered through FACES.NET is in real time with all participants present. While, Kerr & Tinsdale (2004) also note that group members resist changing their initial preferences and/or impressions, thus presenting a challenge that can lead other group members to misinterpret newly presented information that is inconsistent with their preference, the group process in this study requires that all participant views regarding decision making are detailed out for all group members to reflect on and consider in the final group decision.

Chapter 3 Research Methodology

Approach and rationale

This study uses a qualitative research design to conduct an inquiry into the factors that are described by participants in a child protective service agency that influence their decision making specific to a formal response to families where there have been concerns regarding child maltreatment. The methodology was phenomenological (Bogdan & Bicklen, 2007), signifying that its purpose was to understand the complex perspectives of participants in a group decision making process as they constructed and interpreted their personal meanings regarding the factors they consider in pathway choice following the screening decision in a child protective service agency. Through a close exploration and examination of these individual experiences, I sought to capture the common features (factors) and their meaning as applied to the pathway decision. I used grounded theory for guidance in making sense of the data (Glaser, 1998; Glaser & Strauss, 1967) using note taking and coding to find themes or categories, to sort the information into meaningful patterns and to develop a typology/framework to describe what I discovered in the data. I utilized a general inductive approach for the analysis of the qualitative interview data as a straightforward means to condense a significant amount of raw textual data into a summary format that could be easily translated into the practice context (Lincoln & Guba, 1985; Thomas, D. 2006). To begin making sense of the data, qualitative interview data were first coded to

the major organizing ideas such as the factors considered in the pathway decision, additional subjective factors and factors influencing referrals on the border specific to either an investigation or a family assessment. Then, in working with a coder in addition to myself, I worked to reduce the data to the following specific categories: identity of the reporter, perceived urgency to see the child(ren), knowledge of family's willingness to engage in services voluntarily, perceptions and assumptions about the family, health and expertise of R.E.D. Team participants, knowledge about supports and resources available to and used by family and family complexity/challenges. Each of these seven categories contains within it finer sub-categories, as described in more detail below. Coding with additional coders was iterative. We held discussions to fine tune our codes until we had agreed on each major category. A framework demonstrating the connection between factor and decision was developed and illustrated.

Service

The Child & Family Services Agency in Washington DC provides child protective services and is organized around specific decision points similar to other jurisdictions across the United States. Entry Services includes the "Hotline" (first call to child protective services) where the decision to screen in (accept) or screen out (not accept) referrals are made specific to child maltreatment. A group process was initiated in January, 2012 and is referred to as the "Hotline R.E.D."

Team". R.E.D. Team (Sawyer & Lohrbach, 2005) is the acronym for Review, Evaluate and Direct.

The information under review includes the reason for referral (content of the report) to child protective services and the team has immediate access to their formal electronic information system for prior history with child protective services in Washington DC as well as any current open family services at CFSA. Recommendations made by the Hotline social worker and/or supervisor regarding response time are additionally considered. All available information is organized through the Consultation & Information Sharing Framework® (Lohrbach, 1999) to aid in critically thinking through the decisions that must be made.

The available information is evaluated against statutory criteria describing the thresholds and definitions of child abuse and neglect in the District. These definitions are provided through the Structured Decision Making® System (Children's Research Center, 1999) Policy & Procedures Manual Child Abuse & Neglect Screening Assessment District of Columbia Child & Family Services Agency (April, 2013). Following the review of all available information and the evaluation against criteria, a decision is directed by the R.E.D. Team specific to screening in or out for further child protective service response.

In September, 2011 the District of Columbia's Child & Family Services Agency implemented a differential response system whereby choices are available in how the agency responds to reports of child maltreatment. In October, 2013 the

District secured additional positions to fully implement their differential response. For those referrals screened in for further child protective service involvement, a second decision is made by the R.E.D. Team. This decision is commonly referred to as the “pathway decision” in a differential response system. Guided by the District of Columbia’s Child & Family Services R.E.D. Team Response Decision Tree (October, 2013), the team will determine whether a forensic investigation or a family assessment will be conducted.

Site

Washington DC is a populous urban area on the east coast of the United States. According to the 2015 US Census Bureau the estimated population is 672,228 spread over a land area of 61.1 square miles with 10,994 persons per square mile as reported in 2015. Washington DC is predominately Black (49.5%) and White (35.8%), with Latino (10.1%), Asian (3.9%), American Indian & Alaska Native (0.6%), Native Hawaiian and other Pacific Islanders (0.1%) comprising the total population by race. The median household income from the 2015 data is \$75,628 and the persons below the poverty level percentage are 17.3%.

Washington DC is both an important and interesting site in particular because of the intense scrutiny CFSA has been under for decades – currently under a consent decree that has been in force since 1986. CFSA is monitored by a Special Arbiter (Center for the Study of Social Policy) and is under the oversight of the Superior Court of the District of Columbia. The implementation of differential response, group decision making processes, enhanced screening,

and more rigorous practice around critical thinking is part of their improvement plan to address the required exit standards. Additionally, there is much interest in the child welfare field regarding decision making and there is a scarcity of information in the literature specific to pathway decisions from the perspectives and experiences of the individuals either making the decision or participating in a group that makes the decision. CFSA has a relatively recent implementation of differential response and R.E.D. Teams as well as having implemented Structured Decision Making® at the Hotline – this study presents an opportunity to understand the factors that are being considered by the participants themselves when making a decision about responding to child maltreatment concerns through a traditional forensic investigation or the newer concept of a family assessment. CFSA has engaged the Institute of Applied Research, St. Louis, MO in an evaluation of its differential response system and this study can provide additional information to that process for CFSA and to the growing body of knowledge in the child welfare field's focus on differential response. Prior to January, 2012, the screening decision in the District of Columbia was made by individual practitioners and/or their supervisors and their workloads were specific to the hotline duties of taking the calls from the community and making the decision to screen in or screen out for subsequent child protective services. Prior to 2012, the District was screening in 90% of all reports and following the implementation of R.E.D. Teams that percentage had dropped to 55% in 2014. It is important to note that during this time frame there was a substantial increase in

reports specific to educational neglect and 75% of the families receiving a family assessment response were due to a primary concern regarding school absences. With full implementation and staffing for differential response, it will be interesting to see what the breakdown of referrals looks like in the initial and more in-depth evaluation report that the Institute for Applied Research disseminates. The implementation of the R.E.D. Teams in January, 2012 changed the primarily individual decision to a primarily group decision and broadened the membership of those involved in making the decisions.

Participants

Twenty professional participants were recruited in collaboration with CFSA as a purposeful sample based on their involvement in the Hotline R.E.D. Teams, their experience with families with children who have been referred for child maltreatment concerns and their willingness to participate in this study. The participants involved in the sampling all have relevance to the research questions which seek to understand the factors considered in the pathway decision making process from the perspectives and actual experiences of those people contributing to those decisions. CFSA applies decision theory principles within the Hotline R.E.D. Team through the use of a decision tree as well as the Consultation & Information Sharing Framework® both of which aid in the separation of relevant information from “noise” and both of which assist in the breakdown of problems into component parts. The Decision Making Ecology describes the complex interaction between factors such as law, policy, and family

characteristics in the decision making process. I was interested in understanding whether what goes on in the participant experiences and accounts of the factors they are considering when making a pathway decision can elaborate on these theories and to what extent these theories and aids have any significance in the decision making process in the views of these participants as they describe their own experiences.

The participant's professional experiences ranged from 1 year to 32 years and their positions included child protection hotline social workers, child protection assessment and investigation social workers, child protection in-home and permanency social workers, social work supervisors, program managers/administrators, lawyers, family team meeting facilitators and nurses from the governmental sector. Participant's experience in the R.E.D. Team ranged from 8 months to a maximum of 3 years. Participant race/ethnicity was representative of the earlier referenced demographics of the District with the highest percentage identifying as Black/African American. Twenty participants were interviewed and "saturation" was reached with no new themes emerging.

The R.E.D. Team as a group process and the decisions made (screening and pathway) represent a complex social action under study in one site and I sampled within the site to ensure that what is being observed within the interview process is typical for this site. There are currently three different Hotline R.E.D. Teams per day (morning, early afternoon and later afternoon/early evening). The participants were from all three teams. The membership of each Hotline R.E.D.

Team is diverse in terms of gender, race/ethnicity and profession. All individuals who are involved in the Hotline R.E.D. Teams and were willing to participate in this study were included in the participant pool.

Researcher

Qualitative research is an interpretive process and participants may be responding to me as an insider. I have spent prolonged time in the field site since October, 2012 as a consultant. I have spent at least a week per month from October, 2012 through the timeframe of this study on site working across all administrations including entry services (hotline, investigation and family assessment), in home (ongoing field services), permanency (ongoing field services specific to children and young people in out of home care, kinship services including diligent search activities, adoption services, and family group decision making teams), well being (nursing staff, domestic violence specific services, mental health and trauma systems therapy, and the office of youth empowerment), program operations including the child welfare training academy, child fatality, critical incidents and quality service reviews) and the technology teams for the inclusion of the Consultation & Information Sharing Framework® into the electronic information sharing system. I have established trust, rapport and credibility across administrations and all levels of leadership and practice. This has allowed me access and opportunities for observation over time. I am the developer of the process utilized in the site decision making process and have participated in training participants, providing ongoing clinical consultation,

technical assistance and fidelity reviews. I have extensive experience in the public and private child welfare sectors – as a developer, system designer, clinician/practitioner and researcher. I have led multiple large scale implementations of differential response. Specific to my relationship to participants in this study, there were a number of participants I knew well and others I had never met. I was particularly mindful of how my relationships may affect their willingness to participate and/or share candidly. I noted that all participants were willing and eager to participate, to fully utilize the hour time duration of the interview and easily elaborated on their responses when queried for detail. No participants declined to respond even though they were invited to do so at any time they preferred not to answer or elaborate.

Procedures

I conducted individual audio taped face-to-face semi-structured interviews lasting approximately 60 minutes with participant written consent. All participants were thanked in advance for their time, willingness to be involved in this study and introductions made. Participants were apprised that this study was specific to their inclusion in the Hotline R.E.D. Team and to their perspectives and experiences with the pathway decision following a decision to screen in a referral to child protective services. This study will additionally contribute to CFSA's differential response evaluation process regarding factors and themes considered in decision making. I was open and transparent in differentiating my role as a consultant to CFSA in child welfare practice improvement and in the

development of the R.E.D. Teams from my role as a PhD student with the University of Minnesota School Of Social Work completing my dissertation. The interviews took place in a private location of the participant's choosing.

I described that participants could expect the interview to take no longer than one hour and that I would be taking notes and audio taping the interview to ensure that I capture all information. I assured the participants that all responses are confidential and a number will be assigned to each interview transcript and would only be available to the research team and that any comments utilized in any report will not identify them as the respondent. I was clear with them that they could refrain from talking about anything they did not want to and they could end the interview at any time without penalty. I asked for any questions they may have about anything I have outlined and/or any further questions about the study. I again asked them for their willingness to participate in the interview and their permission to take notes and audio tape the interview.

I described that although there is some structure to the interview they could expect a conversational tone. I described that I would be asking some demographic information such as years of experience in child welfare, experience in the Hotline R.E.D. Team, profession, and self-identified gender, race, and ethnicity. I prepared them that I would ask them some questions about child protective service referrals/reports presented in the Hotline R.E.D. Team that they struggled with regarding pathway decision – on the border of decision making – those that could have gone either family assessment or investigation or

an illustrative case that they may have disagreed with the decision that was made. I shared with them that I would query for additional detail from their perspective.

Following the preparatory statement, I asked if they were ready to begin. I began by asking them to describe their understanding of each pathway response – investigation and family assessment. I asked them to take a few moments to recall one or two referrals/reports that were on the border – could have gone either investigation or family assessment and asked them to describe in as much detail as they could remember. I asked about what went into their thinking about a pathway choice and what factors they thought were influential in the decision and whether the decision was investigation or family assessment. I asked what they think the implications would be for decision making regarding the pathway decisions in the R.E.D. team. Depending on the responses, I asked natural follow up questions to ensure that I had captured what they were describing and reflected back to them what I had noted to check accuracy of my accounting. I asked if there was anything else they would like to add.

In closing, I discussed with each participant that after I finishing the 20 interviews, I would go through an analysis of the data coding themes that emerged – I will share the findings in written form as an executive summary and presentation/discussion with participants and leadership at CFSA. I gave my contact information should they have further questions and thanked them again for participating in this study.

Data processing and analysis

Twenty interviews of child protective service social workers, attorneys, and nurses at CFSA were audio-taped and transcribed verbatim. I additionally took notes during the interviews to capture any observed paralinguistic cues – the nonverbal elements such as intonation, facial expression, body posture, etc. that may have modified the meaning of verbal communication (Burgoon & Hoobler, 2002). I engaged a graduate school student to transcribe the interviews verbatim and ensured that the person had access to my notes and was trained on documenting any auditory cues to ensure as much accuracy of meaning as possible during the transcription process.

Specific to this qualitative study, I used a general inductive approach for analyzing the data (Bryman & Burgess, 1994) where the study findings emerged from the significant themes discovered in the raw data derived from the interviews (Thomas, D., 2006). I read all transcripts and identified themes focusing on the experiences described by the participants and emerging meanings. I enlisted a professional colleague who also read the transcripts and we sorted and organized into themes or categories through repeated readings (Schwandt, 2003) – utilizing discussion for continued refinement, exploration of new aspects of themes that emerged and in order to reduce redundancy in theming. I utilized coding, working with the verbatim audio-tapes of the interviews and subsequent transcripts to generate the themes or codes and worked to refine the meaning of the themes, developing an understanding of the pathway

decision making process. By the twentieth interview no new themes emerged, saturation was reached. The process of coding for themes assisted in reducing the data into manageable bits that then could be rearranged through a common language for interpretation into typology (Patton, 2002) specific to the pathway decision making process as experienced by the participants themselves.

To assess trustworthiness (Lincoln & Guba, 1985) I addressed credibility in this study through multiple lenses. As a researcher, I determined that the data had been saturated enough through the coding of all twenty interview transcripts to establish an understanding of meaning through the development of summary themes from the raw data. Specific to this study, I have spent prolonged time in the field site since October, 2012. I have established trust, rapport and credibility as a consultant that has allowed me access and will provide me the opportunity to compare observations over time and interview data. Participants were familiar sharing information with me and I had the opportunity for reciprocity by engaging them throughout the process and will be giving back to them the results of this study (Fetterman, 1989). Close collaboration with participants throughout the study through active involvement provided another lens by which credibility of their narratives was enhanced and is consistent with the kind of relationship I have with CFSA. At the completion of each interview, I summarized the data for each participant to allow for their immediate feedback and clarification as a way to member check and build in participant views as part of the study. The third lens I utilized to establish credibility was that of the external individual. I enlisted

a colleague who is apprised of my research objectives to additionally code with me – reviewing all transcripts of raw text to also create themes. I used peer debriefing (Lincoln & Guba, 1985) with another professional colleague who is knowledgeable about this study and well versed in the subject matter specific to differential response in child protective service delivery to further address credibility in this study throughout the process as a support, a sounding board, and to push me by asking critical questions about my interpretations and methods.

The following table represents the coding process I used where reading through the text yielded 125 segments of information that I labeled to create 22 initial categories. I continued to revise and reduce the overlap and redundancy among the 22 categories, resulting in 13 refined categories. I further refined the categories to arrive at the 7 most important categories (factors). In the findings, I also describe the supporting themes (sub-categories).

Table 1: The coding process

Initially read through text data	Identified specific segments of information	Labeled the segments of information to create categories	Reduced overlap and redundancy among the categories	Created a model incorporating most important categories
282 pages of text	125 segments of text	22 categories	13 categories	7 categories

Note: Adapted from Creswell, 2002, Figure 9.4, p. 266, Thomas, 2003, Table 1, p.6)

Human Subjects

The population of human subjects involved in this study included twenty participants who were involved in face to face interviews. No children were involved in this study. All participants were professional staff from the Child & Family Services Agency in Washington DC. The criteria for participation in this study was participants who have been/are involved in the decision making process for child protective services referred to as the *Hotline R.E.D. Teams*. Recruitment was through word of mouth, e-mails from Child & Family Services staff and simple flyers. One issue that bears mentioning prior to the presentation of findings would be that of participant selection. All participants that met the criteria were invited to volunteer. Given that word of mouth was the most utilized way to recruit, participants who might not have been reached for a variety of reasons (on leave, vacation, off site, etc.) would have been naturally unrepresented and their views unheard.

The data that was collected for this study was obtained through individual in-depth interviews with child protective service involved professionals. The risk to participants was minimal. The potential risk may have been the concern on the part of participants that there could be retribution from their employers.

To further minimize any potential risks to the participants and in accordance with the University of Minnesota and District of Columbia's Child & Family Services Internal Review Board requirements, I provided all participants with the following information: the purpose of the study, the kind of data the interviews

will collect, how the data will be stored, methods to ensure participant confidentiality, and any potential risks and benefits. I obtained consent from all participants for their participation in this study and provided my contact information should further questions and/or concerns arise.

All data from the interviews collected in this study have excluded identifying information. Participant data for consent was recorded on a separate document, secured in a locked file and computer passwords protected electronic files. Interviews were recorded on a digital recorder and transcribed with all identifying information removed and a number assigned. Once transcribed, the recordings were deleted.

This study accepted adults of all genders, abilities, race/ethnicity, and socioeconomic, religious and national origin provided criteria are met.

Chapter 4 Findings

Analysis resulted in seven factors that participants discussed as contributors to the pathway decision: (1) identity of the reporter; (2) perceived urgency to see the child(ren); (3) knowledge of the family's willingness to engage in services voluntarily; (4) perceptions and assumptions about the family; (5) the health and expertise of R.E.D. Team participants; (6) knowledge about the support and resources available and used by the family; and (7) family complexity/challenges.

Theme 1: Identity of the reporter

Perceived credibility and power: Participants identified that they paid particular attention to the detail about the nature of the caller's position and expertise within the community regarding the presence or absence of the caller's familiarity with the child(ren). The pathway decision appeared to be more likely an investigation when the caller held a professional position AND expressed concern AND had daily contact with the child. This kind of information about the caller was described by participants as helpful in discerning whether the referral described an allegation of child abuse/neglect yet did not necessarily raise a significant concern about child safety. An experienced participant attorney noted:

"Some sort of information from the reporter themselves, like, 'I am the case manager, and I am calling...' or you know, it's the school social worker. Like somebody else who has a good handle on what's going on with the family and sort of their level of 'this just is not right,' like 'this is total deviation from the normal behavior we've seen,' or 'This is pretty consistent

and we just want to call it in because of this recent disclosure or this recent episode.”

Participants suggested that information that described a relationship between the caller and the child(ren) also aided their decision making process; they suggested that the caller may have an investment in the well-being of the child(ren) they are calling about. A participant social worker with more than fifteen years of experience in child protective services described:

“If maternal grandma calls it in, I tend to take it a tad bit more seriously because most moms aren’t going to call on their own child if they’re not really concerned about their grandchild so I always tend to take that caller a bit more seriously”

Some participants discussed the consistency of contact that the caller had over time with the child(ren) believing that frequency and pattern of contact better informed timelines regarding the incidents or issues of concern as well as an understanding of child vulnerability. A relatively new participant attorney discussed:

“It’s one of the parents and it’s a custody dispute or sometimes the reporter will make all of these allegations, but then admit that they hadn’t seen the kid in a certain period of time. Whereas if it’s a mandated reporter, or someone that sees the kid on a daily – that’s the big thing. Someone that shows they have seen the kid on a daily basis, or their report reflects is yesterday or it just happened, whereas if you’re talking allegations from like

a few weeks ago or a year ago, that isn't as important as the concerns that are happening now".

Persistence: Any known history of previous referrals originating from the same caller emerged as a contributing theme in the pathway decision process. Many participants indicated that the pathway decision was more likely an investigation when there have been repeated referrals regardless of caller attributes; this decision appears to be based on the increasing escalation of information presented by the caller where there is reference to increased levels of concern. One of the original R.E.D. Team participants, an attorney with twenty five years of experience noted:

"There is the persistence of the caller because sometimes we have the same caller who has called several times and the first few times there are no results and then they are calling and saying something slightly different this time; (and we say) let's just go"

Provision of quality of information: Participants commented on the presence or absence of details regarding the concern(s) specific to the care of the child(ren) and/or environment the child(ren) are living in or exposed to, any known information specific to the presence of resources available to the family, any known negative impact on the child(ren) including physical injuries, illness, death, emotional and/or behavioral distress, negative developmental consequences and/or academic decline. Participants' discussion appeared to be related to their confidence that the hotline social worker had asked clarifying

questions and that they have access to enough detail to avoid their own speculation or escalating concerns about the unknown leading to a decision based on thinking the worst; feeling confident that the question of “unknown or unasked” is settled prior to R.E.D. Team. One social worker participant with fifteen years child welfare experience voiced the frustration that accompanies limited information in the context of critical decision making:

“The gray area.....could be that the reporter may state that the child was hit, but they can’t- they didn’t provide any information about if there was a bruise, what did it look like..... those concrete things so we know actually that the child was hit. And so.....that leaves us saying, “Okay you’re saying that the child was hit, but you don’t indicate that there was bruising or anything like that.” So that can be a gray area. Or sometimes if we don’t actually know the age of the child so we can determine vulnerability..... that age is a critical factor in being able to make those decisions and so we’re kind of on the line until maybe we can research and find more information because sometimes we don’t have dates of birth..... based on what the reporter has given us. So then that creates a gray area and people are teetering on how to move and what I have seen in those situations is erring on the side of caution and saying, ‘okay, we’re going to screen this in because we just don’t know – we don’t have an age – we don’t know that, but we do know there’s a safety concern.’ That if the child were this particular age we could definitely respond in either way, whether it’s family

assessment or whether it's an investigative type of a response"

While it appears to be troubling when the information in general is incomplete and/or unclear, participants expressed added difficulty when the team had an overarching vote of no confidence that the hotline social workers asked the clarifying questions. Two experienced participants stressed that both the screening and pathway decisions can be strongly influenced by this absence of clarity and confidence:

"No other information was obtained because the caller didn't know, or because we didn't ask. I feel like I'm constantly asking that"

"With a lot of gray area....." I believe most of the time (we) go ahead and accept it because it's that fear of the unknown and we have the worst that can happen opinion so I believe most of the time we do accept those"

Theme 2: Perceived urgency to see the child(ren)

Response time/child vulnerability: Participants described this category as linked most closely to the District of Columbia Child & Family Services Agency R.E.D. Team Response Decision Tree (2013) where there is documented and posted guidance on child age, history, and allegation type with recommendations regarding response times and pathway choice. R.E.D. Team participants' perceptions influence how quickly they believe the child(ren) need to be seen; they are considering available information, in addition to age, such as child special needs, severity of injuries, illness, parental actions/inactions, dangerous care and/or environment, child(ren) expressed fearfulness. Most participants

expressed that the pathway decision is more likely an investigation when there are injuries AND child vulnerability is described. When less information is available, participants shared that the pathway decision is more likely a family assessment based on the prevailing assumption that the family assessment is voluntary and therefore less intrusive. An experienced attorney participant who viewed the decision tree as potentially too restrictive expressed frustration with how the team sometimes reacts to the language in the referral (in this example, “PCP”) and stops considering options for response to the family:

“I think the family assessments are the ones that we are less concerned about the immediacy and safety of the children. It’s like my belief that just because PCP is mentioned in the hotline, it’s supposed to trigger no choice, no family assessment. It has to be an investigation. PCP could just be, there could be a lot of maltreatment alleged, and then one little comment about “I think the person uses PCP, but I am not sure.” If we choose to accept it, we have no choice but to go investigation route because who ever made that decision made that decision because we all know that PCP use is actually bad. It’s harmful. You’re erratic and it could be very dangerous for children. But there isn’t PCP use being alleged. There is PCP use maybe being used. We take things away from family assessment as opposed to putting cases into family assessment. We look for signs to say, ‘not family assessment because of this. The kid is two. The kid is 6 months. Or the hospital is calling us……. Maybe we always start with the

premise of family assessment, or at least maybe that's what I always do. I start with the premise of family assessment and it's like, 'oops, can't because this is the fourth call in the last year.'"

Most participants described tuning in to any information that suggested that the child expressed fear of going home as a proxy for vulnerability, regardless of age; this information is most typical in referrals coming from schools or occasionally the hospital settings. One experienced social worker participant discussed:

"I think the pathway decision kind of comes down to how urgent it is. I keep going back to children and school I guess. Physical abuse – child discloses at some point during the day, and we get the referral, and we're at 5 o'clock R.E.D. Team and the child's like "I'm scared to go home."

Some participants shared concerns describing their observations that although the decision making process is intended for thoughtful and discerning discussion, sometimes the weight of making those decisions, resulted in evidence of default decisions:

"Some feelings that I see: some workers come in and think that every child should be removed. That every case is imminent"

"Sometimes the speculation can create this heightened sense of, even though we know that we don't know, that creates the sense of possible urgency that, we still might need to respond so that's some of the subjectivity that I think, in the back of my mind could possibly taint more of

an objective decision”

Theme 3: Knowledge of family’s willingness to engage in services voluntarily

History: Most participants described this category as one that is specific to current and/or historical information available to them as R.E.D. Team participants and this history includes the views of anyone (including documentation) currently and/or historically involved with the family, whether the family has been or would be willing to work voluntarily. All participants based this on their assumption that a family assessment is voluntary, and whether either currently or historically, there is information to suggest that the family assessment response is/has been effective in responding to identified concerns. Most participants expressed that the pathway response is more likely an investigation if the available information suggests that the family would be unwilling to work voluntarily and similar if the available information suggests that a current or previous family assessment is/has been ineffective in remedying the identified concerns. Participants described that the pathway response is more likely to be a family assessment if there is information available that suggests the family is/has been willing to work with the agency voluntarily and similarly if there has been information to suggest that a current/previous family assessment is/was effective in remedying identified concerns. Multiple participants, regardless of discipline (social work, law, and nursing) expressed this strong assumption that the family assessment is voluntary and it is futile, in the face of a history of service refusal, to respond through the family assessment:

“That’s a big one, you know that services are offered and families have declined. There are also situations where there are open cases and there’s a family assessment and it’s open, but there’s still allegations coming in, which kind of shows that whatever work is being done in that setting isn’t preventing the same actions from occurring”

“Also some of the actions of the parents, whether they’ve displayed actions that would indicate that they would be willing to work in a voluntary capacity as opposed to parents that look like they’re resistant to any assistance from the agency”

“If they’re people that have a history of not complying and not following through, it’s almost a waste of time to send family assessment out there because..... three weeks from now they’ll convert it to investigation because they haven’t complied”

One experienced attorney participant questioned the assumption of the family assessment as voluntary versus the investigation as involuntary and clarified:

“They are all voluntary unless they are in court. Just because the agency substantiates someone; it doesn’t flip it to it being an involuntary case. What flips it from being a voluntary to an involuntary case is that court order saying essentially what all court orders say in the neglect proceedings, which is ‘you have to listen to the social worker. You have to cooperate because if you don’t, there are in fact some serious

ramifications.’ Just because we as an agency decide that they have maltreated their children, that doesn’t make it voluntary or involuntary, but the mentality here is that there is that difference”

Theme 4: Perceptions and assumptions about the family

Speculation/Biases: Many participants discussed the tendency toward guesswork in the absence of clear evidence/information available to R.E.D. Team participants. This discussion appeared to raise the presence of bias/prejudice during the decision making process – concern regarding financial resources available to families and the negative impact of poverty. The pathway decision appeared more often and likely an investigation when the R.E.D. Team participants have less available information, default to organizing around “worst fears” and fill in information gaps with “what if” scenarios, decide that there is so much unknown AND it could be worst case scenario. The pathway was described by participants to be more likely a family assessment when there is less information available and the R.E.D. Team participants operate on the assumption that the family assessment is voluntary and there is an expressed desire to have someone seek additional information. Participants across all disciplines had concerns about organizing decisions around their “worst fears” and indicated that they did not always confront these default positions. One social worker expressed:

“We seem to think that everyone, and sometimes – I’m not saying everybody, thinks the worst of our families”

Another participant, an experienced lawyer commented:

“I think when you walk into a R.E.D. Team, your mindset, for me, I think the worst and then go downward”

During further conversation, a social worker participant offered:

“With a lot of gray area..... I believe most of the time (we) go ahead and accept it because it's that fear of the unknown and we have the 'worst that can happen' opinion so I believe most of the time we do accept those”.

Another experienced participant expressed frankly that:

“The more money that you come in contact with, the more money that you make, the more likely you are that your children won't be removed because the likelihood is that you can hire an attorney, or you can get the people that you need in place to get this thing to work out as opposed to working with pro bono attorneys that are assigned to you that you don't have to pay and you may not have to keep, or you might be able to get rid of. You just never know. I do think, because of where we live, and I think that the people that are more affluent, have a less likely chance of having children in care”.

Intent on honesty in the interview, yet another experienced participant shared:

“If there is a food stamp case, if there's a TANF case, if there's a WIC case, and the more community involvement there is to maintain the family financially – the more likely they are when they come to [the agency] to have more issues because if they're in public housing then they may be in

a place that's not really safe for children because public housing is not like living..... workers are more likely to see *well, the stove's not working, or the family might have some sort of infestation* (participant voice inflection), which is not good for the children, but it's also not causing any kind of detriment to them.....”

Prediction: Participants reflected on their tendency to consider either past experiences with the same family or those experiences that may have similar characteristics and, in the absence of clear information, draw conclusions about the present situation and family based on other known experiences. The pathway decision appeared to be more likely an investigation when the forecasting is based on negative experiences. Participant responses appeared to clearly represent the forecasting of future scenarios or concerns about future scenarios that were most specific to disciplines – social worker’s experiences, lawyer’s experiences, nurse’s experiences. Participants indicated that upon reflection they understood the subjectivity and wondered aloud during the interview process whether these biases help or hinder. On such participant with multiple years of child welfare experience expressed:

“There are times when, if an individual in the group has had an experience with the proposed allegation and what not, sometimes that can be a subjective factor where they think they automatically know

what would typically happen with the family or referral, and they might have a preconceived notion of which way it should go”.

Another experienced participant, during the conversation, outlined the different perspectives given different disciplines, perhaps affecting the weight given the information in the pathway decision:

“Each person has different experiences, but it definitely impacts the decision. The lawyer, for example, is looking ahead for *how this is going to be held in court and how are we going to be presenting it before the judge?* and so on and so forth. Then you have the nurse, for example, looking at medical concerns. For example, she might be thinking, *is the child going to be exposed to the drug? Do they have access to the drug?* Each person is looking at it from their profession. I think in a way, that makes it a little difficult for it to go through a path, but at the same time, it’s beneficial because we are each putting our thoughts together and come to some consensus on what pathway”.

An experienced attorney participant shared a similar point based on professional discipline:

“I think the majority of the times I’m thinking about what happens if it ends up in court and how things will play out and how it will read in the narrative in court when we, you know, left things alone, or didn’t go out, or went family assessment, or didn’t get substantiated..... On occasion I have found myself arguing more, feeling more.....

arguing - being like “why aren’t you guys concerned? Why aren’t you outraged? Why am I the only one in the room who thinks this is terrible?”

An experienced social worker also expressed acknowledgment of professional differences in perspectives:

“I really feel like people have their own idiosyncrasies and have their own experiences, and particularly when you have people who have done this work and been in the field doing it – all of that comes into play, and they will start talking about “well this is what happens in these cases when we go out...this is what happens... I feel like that is really dangerous ground to be on, and I understand that you can’t keep your own personal, subjective feelings out of it. It’s impossible. But you have to recognize that you can’t allow your practice, or what you’ve experienced in the field on a different case to affect or influence the decision that you make in this case because we don’t know a lot about the case at that point”.

During this participant interview, this experienced participant made the point regarding a kind of “benefit of the doubt” that is sometimes present:

“We’ve never seen these people before, we’re more likely to say family assessment as opposed to a family that we’ve seen before with educational neglect whose children actually failed the previous school

year and they've been reported by the school and people in the community"

Personal feelings/empathy: Participants reflected on their personal experiences as parents and people in the decision making process and shared being honest and transparent about them and how that might impact the decision making process. The pathway decision appears unaffected regarding preferential influence when the group has open discussion regarding personal feelings/empathy and multiple participants acknowledged that such disclosures can offer an opportunity for improved decision making. One experienced participant lawyer voiced appreciation for speaking up during the decision making process:

"One of the proudest moments I had participating in a R.E.D. (Team) when I – I will project all the other people that were wrong like me made – where we were angry at the caller because we could prove from our FACES (electronic information system) history that the caller had called before and lied, but we didn't know that the caller had called and lied this time, but we were just mad because this caller called and we had proof that they lied. We said no response ('screen out') - . But one person spoke up and that person was the 'lowest ranking person in the room' (newest and less experienced) and she felt empowered to speak up and no one said, 'Who are you? You're the 'lowest ranking person' (newest and less experienced) in the room.' And she spoke up

and said what she had to say, and I realized that I was wrong... that I was angry at the caller. I forgot about a child welfare response needed to protect the child. It's like, 'oh you're right. Of course we have to have a child welfare response.'"

Another experienced participant self-disclosed the emotions she experienced listening to the referral information:

"I was thinking about how overwhelmed that mother was..... I'm considering the effect of sending a child protection social worker, whether an investigator or a family assessment social worker – it's traumatizing"

Two social workers who participated in the interview process shared that being honest with themselves and others on the team assisted in both humanizing the decision and the acknowledgment allowed for meaningful discussion and contributed to an openness to alternative views in order to arrive at a group consensus:

"My mommy instincts..... I slipped into mommy-mode and I felt her pain as far as a mother is to her child"

"I think that there is compassion, and there are feelings – that these are actual people in these cases, and even though we are just reading about them and we can't see them – I think it brings a certain level of compassion"

Several experienced participants from different disciplines noted the often unspoken tension in the room between those team members who are parents and/or have parenting responsibilities themselves and those who do not. They go on to express how helpful it is to have an open conversation about those views:

“I think people who have children make different decisions and there have been many times because I do have children and I have older children who aged out of my house and I had a totally different way of raising my children than other people have and I don’t think anyone is more correct than the other. There are many times where someone would say, ‘I would never leave that nine year old alone under any circumstance even for ten minutes,’ when other people would say, ‘Well I would.’ And that doesn’t matter whether you’re a program manager, the director, the nurse, attorney, or a hotline worker entry level. That matters on what differentiates you on being an actual parent”

“Their own experience as well as the cultural value that the way their own kids have been raised tends to influence their decision making or the way they see those reports that are being brought to us, but then that’s where we [consult] the decision tree, which is like a guide for us”

Interpretation of gray area information: All participants discussed the challenges presented with unknown or incomplete information and

noted that the screening decision itself appears to be influenced by this category in one of two ways: Either the R.E.D. Team participants conclude that there is so little information available that the decision is to screen out OR the R.E.D. Team participants conclude that there is so little information available that the decision is to screen in. The pathway decision appears to be impacted when the conclusion is that there is so little information available that the decision is to screen in and based on the R.E.D. Team participants' assumption that a family assessment is voluntary and therefore less intrusive, the pathway of choice is a family assessment. One experienced participant summed this dilemma up:

“With what we know, are we comfortable screening it out. I am okay even making it family assessment because I figure that family assessment is going to just convert it to investigation if they go out and figure it's something...so I am okay with that. With the screening out it is - do we have what we need to make the decision? And if we don't, there is absolutely nothing we can do about it because this is all we have. Then just hoping and praying that we got the right information to make the decision”

Theme 5: Health and expertise of R.E.D. Team participants

Skill of the facilitator: Participants described the importance of the skill of the facilitator to maintain focus and discipline in the group process and their competence in engaging all participants, promoting discussion, encouraging

dissenting views, and reaching consensus. The pathway decision was described by participants as more likely a family assessment when the facilitator is skilled in eliciting robust discussion examining all available information and views. Multiple participants with varying years of experience stated the significant contribution of the facilitator in the decision making process and, in particular in assisting with critical thinking and consensus building:

“I think a good facilitator starts to sort of weed through the speculation and bring everybody back to what the facts are”

“The facilitator did an EXCELLENT (participant emphasis) job of reframing the thought processes around what was reported, and the group – we opted for a family assessment..... the facilitator was really good at saying, “let’s look at the facts. Let’s go back and look at the facts. Let’s look at what we have, and then let’s make a decision. We do agree that there should be a response, but let’s look at this, and let’s vet appropriately.” You know, he did a really good job of being able to say, ‘yes, decisions may have been made in the past where situations like this would typically go in the investigation route, but we have an opportunity to service this family in a different way so let’s talk through that, and what would that look like?’”

Participant expertise/differences: Several participants discussed their views on the strength of diversity present in the room. The emergent theme was described by participants as linked to the likelihood of increased depth of

discussion when the facilitator is skilled in eliciting such discussion. One participant attorney with long term child welfare experience acknowledged the necessity of inclusion of racial and socio-economic diversity of decision makers in child protective service decisions that have lifelong impacts on children, young people and families within communities:

“If it was all middle class people, and dare I say if it was all white middle-class people, the decisions would be different than with the various people we have in the room. I think it would be different if it was just a bunch of people who are of lower socioeconomic strata who don’t have graduate degrees. I think those decisions would be different also. I don’t think that would be good. It’s good to get different opinions”

A social worker participant in the interview process recognized diversity across disciplines and knowledge domains and discussed the importance of strengthening the decision making as much as possible:

“I don’t have the perspective of the lawyer or the nurse. It’s helpful to hear it, but I don’t have it so sometimes my perspective may be a little stronger or weaker depending on the situation”

Another participant indicated the need for both subjective and objective views presented in the decision making process, underscoring the importance of the contribution to robust conversation/discussion in thinking through the available information to arrive at the very best decision possible on behalf of children and families:

“So you have to be able to separate your feelings from your professional judgment, which is a thin line so I think both your feelings and your professional judgment will be a factor in it. And then listening to the team as you talk through the situation because everybody has an opinion and there may be things that are of very much value to you that they’ve brought up that your mind hasn’t wrapped around yet. It’s a big, important job to sit in a R.E.D. Team because it really can make the difference in a child’s life”

Two experienced participants surfaced during the interview process the issue that can arise where both the screening and pathway decisions could be subjectively influenced by workload if the makeup of the group was limited to those who would be impacted by those decisions – meaning for example that if the workloads were high for family assessment social workers, they may make stronger arguments to influence a pathway decision toward investigation or vice versa. These participants discussed the value of having participants on the team who were not necessarily directly or immediately impacted by the decisions at hand:

“I think we need those people in there who are not directly impacted because otherwise we become protective of ourselves and our staff”

“I think it helps that when I am feeling overwhelmed because of my workload, the other partners are not feeling that and so it’s not me making the decision solely. So even if I am thinking “oh that is BS, we could screen that out” – luckily I am not the only one making that decision, and I can’t

just unilaterally make that decision”

Participants feeling overworked/overtired/overwhelmed: Multiple participants discussed the impact of the overall health and wellness of the R.E.D. Team members on any given day/night. The R.E.D. Team was discussed as a process that requires mindfulness, participation, attention, endurance, focus and discipline and employs critical thinking and robust, engaged discussion in ensuring that the best decisions are made regarding the safety and well-being of vulnerable children, young people and their families impacting communities. These decisions were noted have both short and long term consequences for families. Participants recognized that both the screening decision and the pathway decision appear to be negatively impacted by participant fatigue, workload stress and ill health; either decision appears more likely to be rushed and therefore less likely to have an engaged and thorough discussion. The pathway decision appears more likely an investigation when R.E.D. Team participants listen to repeated screen out decisions with what they describe as the same theme. One experienced nurse participant expressed concern about the overall well being of participants and noted the possible negative impact on decision making:

“When people are overworked, overtired...when they’re getting case after case or when it looks like some of their concerns aren’t being heard, then sometimes they might be a little – a bit of an attitude of *let’s get this over with. Let’s just get this done*. And I’m not saying people aren’t listening or

that they're not doing the job, but I'm saying that all of that can impact how people hear something or how they view what the impact of the decision is going to be."

A number of participants commented on their perspectives of the fatiguing nature of the ongoing lawsuit and court monitoring that the District of Columbia's Child & Family Services Agency is under. One very experienced participant detailed that perceived impact:

"People are so overwhelmed with their own work because of the sheer number of referrals that come into this agency for this small city. It's pretty intense and we have limited resources and then the social workers get overwhelmed and the supervisors get overwhelmed and then the program managers get overwhelmed because we only have 30 days to complete an investigation. They try to close everything out so they can meet – since we're under court supervision, court monitoring, everyone is so like – we have to reach these benchmarks"

Upon reflection in the interview process, another participant discussed the negative effects of fatigue on decision making and the overall importance of personal health and wellness:

"I think when you're tired; you're less likely to take that deeper look to try to make a more sound decision with regard to whether we're going to go to a family assessment or investigation. When you're fresh-brained, rejuvenated, ready to work, you're willing to think more deeply about what is going on

and try to make a more logical assessment, but when you're tired, it's more about completion as opposed to deep thinking."

Theme 6: Knowledge about supports and resources available and used by family

Supports, community links, and meaningful relationships: Participants described the importance of any known information specific to the presence of assets, resources, capabilities within any individual family member, the helpful nature of family/extended family/kin relationships and supportive community connections. They discussed that the pathway decision may more likely be a family assessment when there is information available specific to details regarding supports – often equating that with additional “eyes on the children”. The pathway decision appeared more likely an investigation when there is an absence of information regarding supports AND the R.E.D. Team participants engage in speculation regarding worst case scenario. The pathway decision was noted to more likely be a family assessment where services are listed under strengths/protective factors absent any detail regarding helpfulness of either provider or service AND the R.E.D. Team participants engage in concluding that those services and those providers are connected to family members in meaningful ways that enhance a protective environment. Three experienced participants discussed in detail the process the group goes through in working to identify meaningful family connections and protective capacity:

“.....discussing families so it's not just about what this report says, but let's talk about this *family*. And, do they need us in this way? And in what way do

they – do they need us in an investigative way? Do they *need* us in a way that warrants a family assessment? The need. I've seen that so that's a good thing. Being able to talk about families, you know, use the genogram to be able to identify who family members are, and just understanding the family or origin and the supports"

"We actually consider strengths on our board when we are doing that.

Especially if someone has had an experience with that family. I know people have actually brought up what they thought was a good thing about them, or if the mother followed through with something in their care"

"If there are other family members that are involved with the children. If the children have good relationships and are staying with family members more frequently than at home..... If the family members were the people that actually made the hotline call because a lot of times, when there is a large family, it is indeed a family member that makes that call, which makes me think, "okay, there are people that are concerned in this family that may possibly be able to care for the children." When their information is presented as well, when we do a genogram, and if it says there are aunts and uncles and cousins and maybe another sibling is already with this aunt in a family arrangement that could move me closer to a [family] assessment because we know we have a plan already in place"

Theme 7: Family complexity/challenges

Mental health, substance abuse, domestic violence, children's special needs: Most participants discussed at length information that is described to contribute to greater difficulty for the family, its' members, and/or the agency as a significant factor they consider in the pathway decision. The presence of research based risk factors were expressed as contributing (relevant information) factors to the referral information concerns and acknowledged they may be unrelated ("noise") to the primary concerns presented. The pathway decision appeared more likely to be an investigation where there are multiple described challenges, related to the primary concern(s) or not, AND injuries to the child are present. The pathway decision appeared more likely to be a family assessment when the complexity appears to be unrelated to the primary concern(s) UNLESS there is information available that suggests the family is unwilling to work with the agency voluntarily. One experienced attorney participant brought clarity to the summation of the dilemma:

"The substance abuse and the mental health because you're directly talking about a compromised parent, a compromised caregiver, but when I sat back for a second, like the law says you have to show a nexus. You have to show the impact, and a lot of people are substance abusers who are high functioning and a lot of people have mental health issues who are high functioning. So it kind of was reminding me, how old are the kids, what is the level of care, what is the evidence that the level of care is being

compromised? So it shouldn't be automatic to investigation. You really do need to go back and look at your actual circumstances.”

Three additional participants with variable years of experience expressed the dilemma inherent in considering well-being, particularly in the context of a somewhat more narrowly defined national primary focus on safety:

“It's not clear that there's neglect at all, but it's clear that the family is in need of help. Whether it's a kid arriving late to school, or the child appears not to have the clothing or the proper care, potentially some mental health issues that are not putting the child at risk, but it's clear that there are some issues affecting the family that are impacting the child, but not so detrimentally that it needs to be an investigation”

“Usually from the report it's not always easy to tell if it's mental health issues or drugs, but any usually, bizarre behavior that might impact the child. If it's bizarre behavior while the parent is with the child is more concerning to me than just if a person has mental health issues, but if it's impacting – it could be the reason why a parent doesn't send their kid to school. Paranoia, delusions, that type of behavior”

“Just having someone who feels it's okay to put their hands on another person or doesn't know how to control their own anger, or there are mental health involved here, is so tricky with domestic violence. Domestic violence is difficult to predict. Difficult what's going to happen next? There are substance abuse issues. So many different factors. It's such a complicated

thing that I always have to sit there and think about it while in R.E.D. Team about “what’s the pathway for this one?”

The following table (Table 2) provides a conceptual framework illustrating the seven themes considered by participants in this study in the pathway decision making process and the resulting impact specifically on the pathway response choice:

Table 2: Themes and Impact on Pathway Decision

THEME	Identity of the reporter (person making the call)	Perceived urgency to see the child(ren)	Knowledge of family's willingness to engage in services voluntarily	Perceptions and assumptions about the family *	Health and expertise of the R.E.D. Team participants **	Knowledge about supports and resources available and used by family	Family complexity and challenges
INVESTIGATION	<p>-More likely an investigation when the caller holds a professional position AND expressed concern AND had daily contact with the child(ren)</p> <p>-More likely an investigation when there have been repeated referrals regardless of caller attributes; this decision appears to be based on the increasing escalation of information presented by the caller where there is a reference to increased levels of concern</p>	<p>-More likely an investigation when there are injuries AND child vulnerability is described</p>	<p>-More likely an investigation if the available information suggests that the family would be unwilling to work with the agency voluntarily</p> <p>-More likely an investigation if the available information suggests that a current or previous family assessment is/has been ineffective in remedying the identified concerns</p>	<p>-More likely an investigation when the R.E.D. Team participants have less available information, default to organizing around “worst fears”, fill in information gaps with “what if” scenarios and decide there is so much unknown AND it could be worst case scenario</p> <p>-More likely an investigation when the forecasting is based on negative experiences</p>	<p>-More likely an investigation when R.E.D. Team participants listen to repeated screen out decision with what they describe as having the same theme</p>	<p>-More likely an investigation when there is an absence of information regarding supports AND the R.E.D. Team participants engage in speculation regarding worst case scenario</p>	<p>-More likely an investigation where there are multiple challenges whether they are related to the primary concern(s) or not AND injuries to the child are present</p>
FAMILY ASSESSMENT	<p>-More likely a family assessment when the caller</p>	<p>-More likely a family assessment when less</p>	<p>-More likely a family assessment if the</p>	<p>-More likely a family assessment when there is</p>	<p>-More likely a family assessment when the</p>	<p>-More likely a family assessment where</p>	<p>-More likely a family assessment when the</p>

	is able to give detail and a more holistic description of the family	information is available based on the prevailing assumption that a family assessment is voluntary and therefore less intrusive	available information suggests that the family would be willing to work with the agency voluntarily -More likely a family assessment if available information suggests that a current or previous family assessment was effective in remedying identified concerns	less information available and the R.E.D. Team participants operate on the assumption that a family assessment is voluntary and desire to have someone seek additional information	facilitator is skilled in eliciting robust discussion examining all available information and views	services are listed under "strengths and protective factors" absent any information regarding helpfulness of either provider or service AND the R.E.D. Team participants engage in concluding that those services or providers are connected to family members in meaningful ways that enhance a protective environment	complexity appears to be unrelated to the primary concern(s) UNLESS there is information available that suggests the family is unwilling to work with the agency voluntarily
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* Screening decision is impacted in one of two ways:

> R.E.D. Team participants conclude there is so little information available that the decision is to screen out.

> R.E.D. Team participants conclude there is so little information available that the decision is to screen in.

- When the decision is to screen in, the pathway decision is more likely a family assessment based on the assumption that a family assessment is voluntary and therefore less intrusive

* *Both screening and pathway decisions are impacted by participant fatigue, stress and ill health: either decision is more likely to be rushed and therefore less likely to have an engaged and thorough discussion

> Linked to the likelihood of increased depth of discussion when the facilitator is skilled in eliciting such discussion.

Chapter 5 Discussion

There has been broad implementation of differential response and replication of R.E.D. Teams nationally and internationally and the dialogues continue regarding decision making specific to pathway response. This study is unique in that it has provided an in depth examination of the factors that influence participant decisions in this site and context; no other studies have done similarly. This study invites the readers to make connections between factors presented in the findings and their own experiences – perhaps selectively applying results of this study in their own child protective service agencies, units or teams.

Social work practice, in the context of child protective services, is carried out amidst much anxiety regarding errors – particularly those that may contribute or be viewed as contributing to a negative outcome for a child. The safeguards that tend to be instituted are linked to increasingly more prescribed policies and procedures – consensus based decision support aids and pathway decision guides that aim to provide direction and consistency variably based on statute, real or perceived community standards, and jurisdiction experience and/or on the experience of other jurisdictions. The themes discovered and explored in this study have provided some insight regarding the actual application and utilization of these support and decision aids and whether and how they may factor in to the pathway decision from the perspectives of those participating in making those decisions – thereby perhaps informing subsequent policy and procedure

development. The conceptual framework that was developed within this study illustrates that participants' perceptions of the contributors to the pathway decision in the child protective service agency are free flowing and contextually interactive.

With respect to intra-group variability, there were a number of responses specific to the impact of differential response on the screening decision that did not fit the themes and that bear mentioning. One experienced social worker expressed that having options in how to respond to families where there are maltreatment concerns offers "more opportunities to examine unintended consequences" welcoming the added discussion that comes with having time and other people to fully talk through a referral. Another attorney participant discussed that "differential response is on people's minds all day, every day because there are constantly R.E.D. Teams meeting and making screening decisions". This perspective illustrates the value in understanding the importance of the first major decision that the agency makes and how that links to all other subsequent interventions (including court activity) and decisions. I asked participants to describe any advice they might have for improvements to the process and one social worker articulated the observation that the "group becomes deferential to authority figures when they sit in – program managers/director – whatever they think is how it goes. Instead it should be how that person has a voice equal to each other participant". This observation brings out the power and authority dynamics present in the culture while at the same

time advocating for equality and fairness in views rather than defaulting to authority and privilege. Another experienced health practitioner participant noted that “different groups promote compassion and personalization, as the various details come to life as workers amplify the issue and make it more understandable” and suggested improving the process by more explicitly growing this kind of culture across groups. When asked about any other additions or suggestions, another attorney participant expressed a suggestion to “do away with investigations altogether and have 100% family assessment response. We could maintain investigation protocols if children need to be placed. This would give families the authentic message that workers are there to help and support”. This comment illustrates the reflective nature of participants in their immersion in a process where they become very familiar with the available options and begin to naturally invest in innovative thinking and practice improvement on behalf of children, young people and families.

The role of supervision in the context of child protective service screening and pathway decision making practices has traditionally been focused on administrative oversight of those decisions as evidenced by check lists that specify supervisor review and/or overrides that are part of the documentation processes. The study results based on actual participant views and perspectives may inform supervision practices in this site - the developmental/clinical and supportive functions of supervision may play an enhanced role in practice improvement. Like many such organizations, CFSA is challenged by high

turnover of staff and leadership, reduced experience levels of practitioners and the public loss of confidence and esteem for the profession(s) associated with child protection work. Reduction of the scope of their work, specifically application of professional judgment and resulting loss of autonomy may have negatively impacted their sense of satisfaction with their work. These unintended consequences are generally not anticipated and accompany increased scrutiny and public criticism resulting in more procedures and compliance based requirements (Lane, D., Munro, E., & Husemann, E., 2016). Every day, these participants face the complex task of finding the right balance of judgment in making decisions that in either direction can have serious consequences; errors do occur. The R.E.D. Team is nested within a child protective service agency which is nested within a larger child welfare system in which the agency is under intense scrutiny and endures strong public reaction when errors are made resulting in increasing procedures and the unintended emergence of a compliance culture which is at significant odds with the decision making process at hand which is fraught with complexity and fear of making the wrong decision – for families. The decisions that must be made regarding child maltreatment echo the definition of what have been called “wicked problems” – those situations that are unpredictable, complex, open-ended, and often viewed as intractable – further complicated by the contributing factors of conflicting values and perceptions of community stakeholders (Head, B. & Alford, J., 2015). Expertise cannot be replaced; many of the tools and guidelines are designed for well-

ordered situations (Klein, G., 2009) rather than these decision making situations that represent the complex, unpredictable and ambiguous with insufficient information available more times than not. Procedures can undermine and erode expertise (Munro, E. 2004). Klein (2009) discusses the dilemma where procedures are helpful in handling typical tasks and less helpful to practitioners in novel situations where tacit knowledge regarding the system in which they are working is critical and where they can develop strong mental models and pattern matching and recognition. The narrative descriptions provided by the participants in this study represent such novel situations, where each family referral and situation brings unique complexity to the decision making process and the R.E.D. Team participants must grapple with ambiguous information and uncertain outcomes within an ecological context of exceptionally high expectations and scrutiny.

This study represented an opportunity to slow down the pathway decision making process in this site and take the time through the interviews to make space for reflection on individual participant experiences – a rare occurrence in child protective services and one that may additionally prompt further application for practices by incorporating such opportunities and participant experience “snapshots” as part of ongoing internal quality service review and professional development processes.

Regardless of profession, position, or length of experience within the child protective service agency or Hotline R.E.D. Team, all participants provided input

and recommended the following as clear and appreciated themes that emerged from the participant interviews specific to the strengths of the screening and pathway decision making process in the District of Columbia; they reflect the nature of the complex task at hand and the innovative process that has been implemented to assist in critical thinking, transparency, and knowledge building. Participants were asked in the interview what they value as the strengths of the pathway decision process and four themes emerged as most frequently cited and most descriptively detailed. The participants expressed appreciation for the multi-disciplinary composition of the group and noted the value of the varying experiences and perspectives – **working collaboratively** “provided multiple ways of looking at the situation” and “many experiences joined together – fieldwork, parenting, diversity of socioeconomic status and educational levels among professionals” developed a “collaborative workspace”. Participants also shared specifically the helpfulness of the presence of legal colleagues, “legal can help understand the legal requirements” and nursing colleagues particularly when the referrals described medical neglect or failure to thrive concerns, “medical professionals are a big asset because they frame the risks and needs well for the team – help make sense of how critical a concern is”. **Sharing responsibility** was discussed through a participant’s description of “shared accountability and responsibility increases investment in the decision making process” and another who expressed gratitude that “it is not just one person’s perspective, we can look at the case from multiple angles, and share the

responsibility among a whole group rather than one person”. Given the anxious environment of a child protective service system culture, another participant offered the expression of relief that sharing responsibility “shares the burden of decision making” and eases the commonly described fears of making the wrong decision. Working within an agency that is under significant and long term scrutiny from the courts and the media prompted acknowledgements from participants that the group process decreases what has become known as fear based decision making and **increases confidence**, describing that there is “strength in numbers – more confidence because the decision was made in a group, so the decision is more likely to be correct” and another participant noted similarly that there is “safety in numbers – the group is more confident screening things out because there is a full process and consensus from multiple workers”. There also appeared to be a recognition of the negative impact that fear has on decision making and another participant tuned in to the “opportunities for feedback, more listening ears because details can be missed, usually increase comfort and confidence to make the decision in a group setting” and another expressed in simple terms the value of “more people listening to carefully consider each detail”. The Hotline R.E.D. Team represents innovative infrastructure to support collaborative practice and was intentionally designed as a learning environment where knowledge is built and managed within the group process rather than within individuals so when the inevitable workforce turnover occurs, the agency itself becomes the holding environment for that knowledge.

One participant described this by sharing that the pathway decision making process “expands knowledge to the agency – exposes parts of the process to the whole group so they understand the full life of a referral from beginning to end” and another offered that the “skills from R.E.D. Team transfer to other services and promote more respectful practice”. **Building expertise** was cited by a participant as “critical thinking has grown in the decision making process – good facilitation can help group members grow in their own critical thinking” and another added that this process “gets individuals out of their own thinking, challenges underlying assumptions and biases” and an additional participant summed up the strengths of the process in the recognition that there is an “increase in discussing *families*. Focus on how a family needs to be served. Do they *need* us in an investigative way? In an assessment way? This process supports getting to know the members of the family and understanding what is happening with them”.

Limitations

The aim of this study was to obtain an in-depth understanding of participant perspectives specific to making the pathway decision in the differential response child protective service system within the District of Columbia. I have been mindful of how my interactions in the interview process may have interfered with participant disclosures given my consultant relationship with CFSA. I was careful to avoid any selective attention to statements that may have introduced unintentional bias into the study results.

I conducted one interview per participant rather than multiple interviews and themes that emerged later in the research process were not probed and the analysis was therefore limited. Additionally, analysis is limited because there is no independent means of assessing participants' full understanding of the actual reasons they choose to make specific decisions.

Implications

This study has provided a unique glimpse into the decision making process within the natural setting in which these decisions are actually made (Haight, 2010; Lincoln & Guba, 1985). Given the nature of the group process, there is transparency regarding statutes that guide the decisions, the information that is available, how it might be organized, and the decision support tools employed. Through the interview process and subsequent themes, the uncertainty that emerged – housed within the missing information, ambiguous information and unreliable information was significant. The importance of expertise – and the ensuing discussions - along with the mental models and pattern recognition based on experience that emerged was equally significant. Perhaps one of the lessons learned would guide us to focus much more of our energy regarding practice on valuing and growing expertise and building and managing knowledge beyond individuals – more procedures undermine expertise. The impact of audits has had a significant effect on social work practice. Their work is under increasingly closer scrutiny and monitoring with the emphasis on documentation rather than the actual interventions and interactions with families. The function of

case management where services to families are brokered by social workers who then monitor compliance has taken time away from skill building and practice in the clinical and supportive functions of engagement, assessment, facilitation, advocacy and intervention. Similarly, the administrative functions of social work supervision have been prioritized over the developmental and clinical functions of supervision. The specific guidance around the details of working with human beings who are challenged by multiple complexities is getting less and less attention. The group decision making process within which the screening and pathway decisions are made within this study provides an opportunity for participants to learn from each other in a supportive environment where there is shared accountability and risk. Because this process is intended to conclude each referral in an agency decision rather than an individual decision there are clear indications of increased confidence in the decision making process where both present threats to safety and protective capacities and supports are thoroughly discussed. The group process additionally provides an immersion experience for learning, onboarding new staff and training. Working in groups allows for the practice of skills that can also transfer into working with family groups. The decision making process is made visible and provides the opportunity for social workers and other participants to more fully understand both the how of the initial decisions are made and how these decisions link to subsequent decisions and practice across a continuum of child protective service system delivery. One of the frequently cited challenges by participants is the

amount of time that it takes to make these initial decisions. This appears to be a reflection of the mandated time frames that are in place for initiation of an investigation or a family assessment. There is no study that has examined the question of “how long should it take” to make a decision with long term consequences that either screens out families that would benefit from intervention or screens in families where such an intervention is unnecessary and unduly intrusive? It would seem to me that taking as much time as is needed to make a solid decision at this early stage would ensure that the best thinking was employed to set the stage for greater efficacy going forward.

Our policies would benefit from an examination of the extreme time pressures these decisions are made within and recognize that these particularly early decisions set in motion a set of significant consequences for children, young people and their families – both helpful and hurtful – and be adjusted accordingly. Future research could be focused on studying experienced decision makers in the human service direct practice context. Unpacking the strategies that are being employed and what they “see” that more novice practitioners do not may better inform our service delivery designs, the education and professional development of practitioners, as well as laws and policies. Additionally, the questions that naturally emerge given multi-disciplinary decision making teams would be important to interrogate. Such a question might be whether individuals from different professions are weighting the various themes differently in a way that might impact the pathway decision process.

We train on policies, practices and procedures. We train on structuring the decisions to determine the pathway. We discover that participants bring their own criteria as well as incorporate training in making those decisions. This has implications in how we prepare professionals and develop our decision making processes.

There has been much discourse and varying degrees of confusion regarding the “voluntary” or “involuntary” nature of investigation and family assessment. This was evident in this study and the theme specific to “knowledge of the family’s willingness to engage in services voluntarily” and the impact of the participant views regarding family willingness to engage in services on the pathway decision further highlights the dilemma. One perspective takes the position that the majority of families are referred/reported to the child protective service agency by other people (rather than the family themselves) and families cannot refuse either an investigation or family assessment (QIC-DR, 2014). Another perspective taken primarily by attorney participants in the study would be that:

“ there are discussions of voluntary and involuntary cases. They are all voluntary unless they are in court. Just because the agency substantiates someone, it doesn’t flip it to it being an involuntary case. What flips it from being a voluntary to an involuntary case is that court order saying essentially what all court orders say in the neglect proceedings, which is “you have to listen to the social worker. You have to cooperate because if

you don't, there are in fact some serious ramifications." Just because we as an agency decide that they have maltreated their children, that doesn't make it voluntary or involuntary, but the mentality here is that there is that difference"

The child protective service intervention is fundamentally an unwanted intrusion into the private lives of families. Dumbrill (2006) describes that most families are thrust into a relationship with the child protective service agency and social worker where there is an ill-defined and poorly articulated power and authority over an investigation or family assessment. Rooney (2008; 1992) in his significant works on strategies for working with involuntary clients clarifies these artificially polarized positions:

"Involuntary clients include both persons pressured to work with a helping practitioner under a legal mandate and non-voluntary clients who experience significant, but not legally mandated pressure" (2008, pp. 116).

This study clearly highlighted that the decision to respond through a family assessment was strongly linked to participant beliefs that a family assessment is voluntary and therefore the consideration of a history that suggested that a family had been willing to work voluntarily was key in that pathway choice. Participants described their perceptions of the family assessment approach in a way that would account for an understanding and acceptance of the natural reluctance that families may have rather than framing that reluctance in a blaming way as "uncooperative". A number of participants across all disciplines described the

family assessment approach in the following ways in their discussions regarding their views on the impact of differential response on child safety and well being:

“Gives more opportunity to engage with families supportively, work on real issues without bringing in punitive measures”. “Families are less intimidated and have opportunities to rectify problems without worrying about substantiation and the agency does not have to compromise safety”.

“Children are as safe being served differently. Family assessment has more time to provide practical help because there is no time spent on making a finding.”

Turnell, Lohrbach & Curran, 2008 in describing lessons from successful practice highlighted that engaging families with a strong emphasis on building a working constructive relationship (partnership) that is based on a common understanding of goals and a respectful and inquiring approach should be the preferred way and is indeed possible to engage families in either an investigation or family assessment.

The significance of the role of facilitation in social work practice, in particular the group process, has implications for future directions in professional development. Facilitation in the context of the R.E.D. Team process is defined as assisting the group to perform with greater efficacy. The facilitation activities are described as: attending to a welcoming atmosphere with clarity of purpose, ensuring the presence of a whiteboard or equivalent and proper writing instruments, asking questions to move from generalizations to specifics and

ensuring thorough discussion and organization of all available information through the Consultation & Information Sharing Framework®. Ideal implementation would: ensure a timely start and closure as agreed upon specific to the number of referrals being reviewed, welcomes all present and manages introductions and explanation of process to any observers or new team participants, prepares in advance to ensure that the room is set up (whiteboard or equivalent and markers available, all additional roles in place – scribe, reader, history finder), actively seeks detail by asking clarifying questions, ensures that presented information is intact rather than paraphrased or interpreted, checks with the group about preferred location of information within the framework, actively reminds the group that speculative, incomplete and/or unknown information would be located within the “gray area”, ensures that all views regarding decisions are included with supporting basis for each participant decision, seeks consensus to reach a decision. These activities form a base for subsequent professional development and training and the skills are transferable to work directly with family groups in agencies that seek to involve children, young people and families in all phases of assessment, planning and decision making that affects them.

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Appendix A

Informed Consent

Assigned Number:

Profession:

Years Child Welfare Experience:

Experience in R.E.D. Team:

Gender:

Race/Ethnicity:

Introduction

I want to thank you for taking the time to meet with me today. My name is Sue Lohrbach and I would like to talk with you about your perspective and experience with pathway decision making in the Hotline R.E.D. Team. You may know me as the Child & Family Services Agency (C.F.S.A.) consultant to practice and the implementation of the R.E.D. Teams – I am in a different role today. I am also a PhD student at the University of Minnesota School of Social Work completing my dissertation requirements. I am interested in the factors influencing the decision making process in a differential response system around pathway decisions. This study will contribute to the evaluation of CFSA's differential response system as well as contribute to the field of social work's knowledge regarding participant perspectives in decision making. The decision to participate or not will not affect your employment.

This interview will take no longer than one hour. I will be audio taping the interview to ensure that I capture all of your comments. I will also be taking notes during the session. All of your responses will be kept confidential and a number will be assigned to each interview with only the research team having access. I will ensure that any information I include in any report does not identify you as the respondent. You may refrain from discussing anything you would prefer not to and you may end the interview at any point without penalty.

Are there any questions about anything I have outlined? If any questions arise, I may be reached at lohr0006.umn.edu.

Are you willing to participate in this interview?

Participant

Date

Appendix B

Interview guide

Preparatory Statement

There will be some structure to this interview and you can expect a conversational tone. This is a dissertation study about about pathway decision making in a differential response system in child protective services. It is about the factors that influence the decision making and the challenges and strengths attributed to the decision making process.

Questions

1. Take me through the steps of your decision making process for choosing the investigation versus the family assessment.
 - What are some of the other, perhaps more subjective, factors that influence your decision making?
2. Take me through an example of a typical referral that would be assigned to the investigative response pathway.
3. Take me through an example of a typical referral that would be assigned to the family assessment response pathway.
4. Think of a referral/report that was on the border – one that could have gone either investigation or family assessment. Tell me about the referral.
 - How did you decide to go either investigation or family assessment?
 - It sounds like, for this referral, X, Y, Z were important factors. Would that be correct? Anything else?

- How typical are these factors in influencing pathway decisions?
 - What are some other factors that may influence borderline referrals (cases)?
5. Tell me about a pathway decision that you might have disagreed with.
 6. In your experience, what are the strengths of the pathway decision process?
 - What are the challenges?
 7. In your experience, how has differential response impacted:
 - Child safety?
 - Family well-being?
 - How decisions are made to screen in referrals?
 8. How does group composition impact decision making?
 9. What advice do you have for strengthening the process (model)?
 10. Is there anything else you would like to add?

Closing

I will be analyzing the data from your interview and the others and I will code themes that have emerged in the pathway decision making from your perspectives and experiences. I will share the findings in written form as an executive summary and presentation/discussion with participants and leadership at CFSA. My contact information is: Sue Lohrbach lohr0006@umn.edu should you have further questions. Thank you again for participating in this study.

Appendix C

Definition of terms

Consultation & Information Sharing Framework®: The Consultation & Information Sharing Framework represents a basic structure supporting critical thinking, applied knowledge, collaborative practice, comprehensive assessment and inclusion. The Framework was developed by Sue Lohrbach in 1999 and is embedded in the R.E.D. Teams.

Differential Response: In this proposal, differential response in a child protective service system refers to legislative permission for jurisdictions to develop more than one response to reports describing or alleging child maltreatment. All responses developed specific to accepted (screened in) reports of maltreatment represent mandated interventions with families during the allotted time frames for the initial investigation and/or assessment.

Family Assessment: Specific to child protective services a family assessment is initiated at the point that a report describing or alleging child maltreatment is accepted (screened in) and additional criteria are met (varies across jurisdictions). The assessment is focused on child and family needs and is without the forensic process. A formal determination of child maltreatment is unnecessary and family support services are offered.

Investigation: Specific to child protective services an investigation is initiated at the point that a report describing or alleging child maltreatment is accepted (screened in). A forensic process of fact finding is initiated with the family culminating in a conclusion, finding or determination of whether child maltreatment occurred or not. Law enforcement may also be involved per specific jurisdiction policies and procedures

Pathway Decision: In this proposal, the pathway decision represents the response choice made once a report describing or alleging child maltreatment is accepted (screened in). One pathway is referred to as investigation and the other is referred to as family assessment.

R.E.D. Team: The acronym stands for **R**ever (all available information), **E**valuate that information (against specified criteria) and **D**irect a decision. The R.E.D. Team was developed in Olmsted County, MN in 1999 and is utilized in multiple jurisdictions nationally and internationally.

Screening Decision: This is the first decision point in a child protective service system. Following a report describing or alleging child maltreatment, the statutory agency must decide based on statutory criteria whether to accept

(screen in) the report as a valid report of maltreatment and initiate an investigation.

Structured Decision Making®: A research and evidence based decision support system. Structured Decision Making was developed by the Children's Research Center, a division of the National Council on Crime and Delinquency.

Appendix D

R.E.D. Teams & Consultation & Information Sharing Framework®

R.E.D. Teams Offer:



R.E.D. = Review, Evaluate & Direct

- A collaborative and disciplined reasoning process
- Applied at strategic decision points throughout the life of a family case
- Using the Consultation and Information Sharing Framework® to build essential understandings via balanced assessments of safety, permanency, and well-being
- Discerning the best course of action based on a proportionate response to child safety concerns and family circumstances
- Guiding selection of interventions and pathways (hotline) leading to positive outcomes for children, families, and service systems

Figure 1: R.E.D. Teams

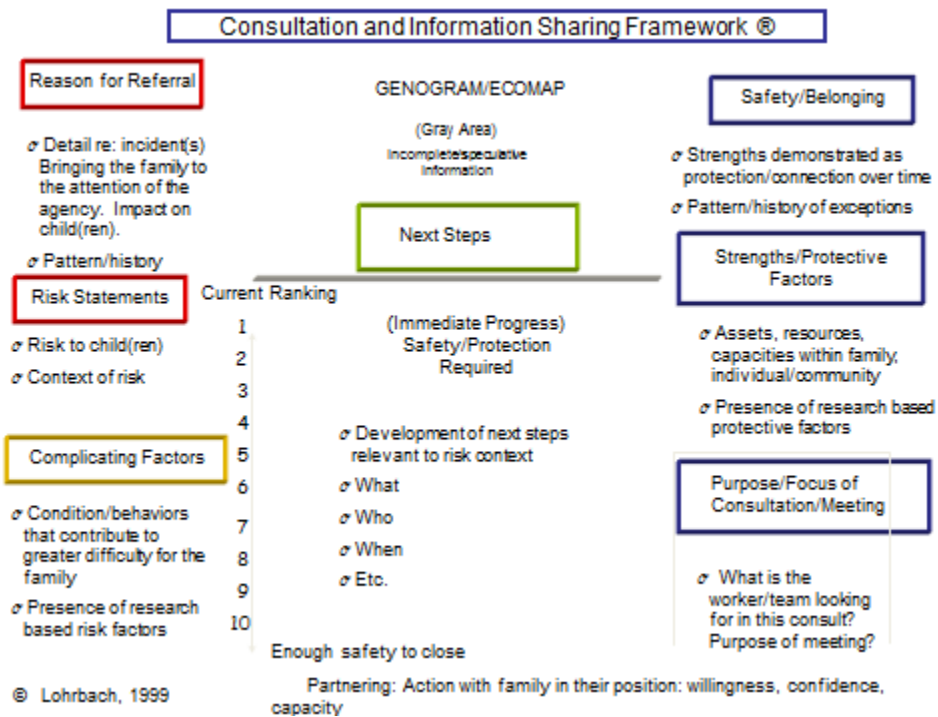


Figure 2: Consultation & Information Sharing Framework®

Appendix E

DISTRICT OF COLUMBIA CHILD AND FAMILY SERVICES AGENCY

R.E.D. TEAM RESPONSE DECISION TREE

October 2013

Do ANY of the following apply?		
	Child fatality or near fatality where abuse/neglect is suspected.	Yes → Immediate Investigation
	Child has a serious condition or serious injury that requires immediate medical attention.	
	Police are requesting immediate response.	
	Child is currently alone <u>and</u> requires immediate care.	
	It is likely that the child will be exposed to harm or unsafe conditions within the next 24 hours.	
	Family may flee, or workers may be otherwise unable to locate family.	
	Other (specify): _____	

↓ No

Do ANY of the following apply?		
	Child age 12 or younger has a visible injury due to abuse or neglect.	Yes → Investigation within 24 hours
	Non-mobile child of any age has sustained bruises or other visible injuries.	
	Referral includes allegations of child access to weapons, illegal drugs, or exposure other criminal activity.	
	Sexual abuse allegation.	
	Alleged perpetrator has a currently open CPS investigation.	
	There is a currently open and active in-home or placement case for the family.	
	Alleged perpetrator or child is involved in three or more investigations or assessments in the past year.	
	Allegation is against a licensed home or facility.	
	Other.	

↓ No

Do ANY of the following apply?		
	Youngest alleged child victim is age 5 or younger.	Yes → Family assessment as
	Alleged child victim is ages 6–12 and without adequate	

soon as possible
and no later
than three days



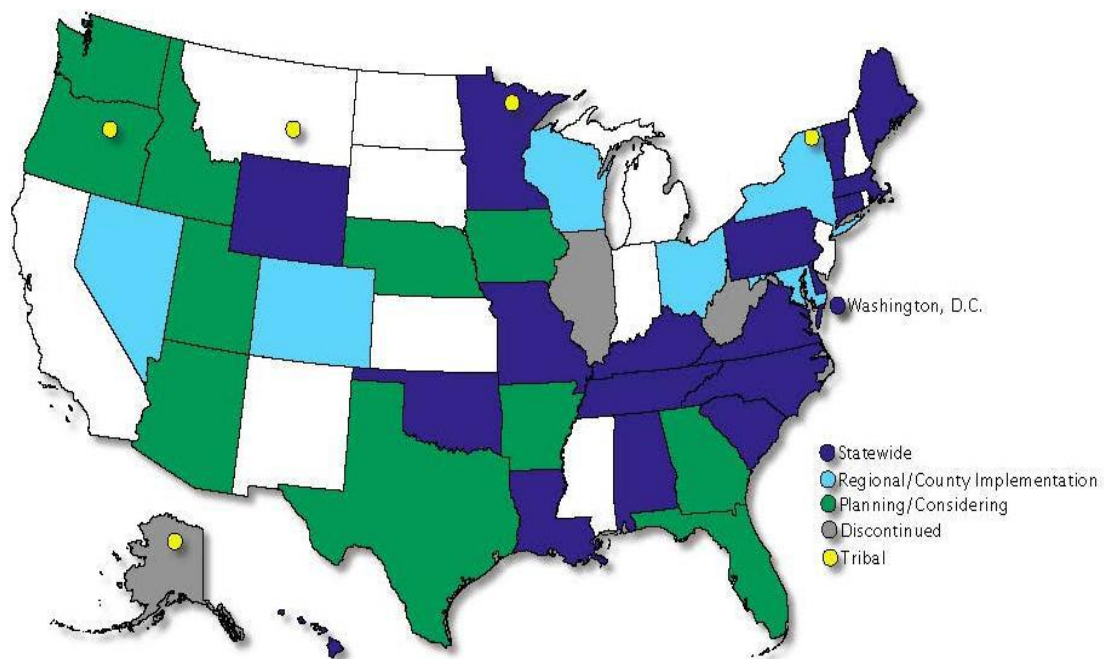
	supervision, food, or shelter.
	Alleged child victim is limited by disability and without adequate supervision, food, or shelter.
	Report includes current concerns of domestic violence or caregiver substance abuse.
	Report includes current concern of caregiver with untreated mental health issues.
	Other.
	Child exhibiting behavior that requires mental health evaluation.

↓ No

	None of the above is present; the report will be assigned for family assessment. Contact as soon as possible and no later than five days.
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Appendix F

MAP OF DIFFERENTIAL RESPONSE IMPLEMENTATION AS OF OCTOBER, 2013



Final Report: QIC-DR Cross-Site Evaluation